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REPORT
of the
DEPUTY MINISTERS of HEALTH, HOUSING, SOCIAL SERVICES
on
COORDINATED HOME CARE

APRIL, 1987

Nova Scotia
Department of Health
Department of Housing
Department of Social Services

REPORT

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COORDINATED HOME CARE

APRIL, 1987

PROVINCIAL EXPENDITURES ON HOME CARE-RELATED PROGRAMS, 1985-86

Housing

1.	Senior Citizens Assistance	$ 5,712,000
2.	Provincial Housing-Emergency Repair	800,000
3.	Small Loans Assistance	750,000
4.	Access-a-Home	115,000
5.	Senior Citizens Public Housing - existing units (Provincial Portion)	3,022,000
6.	Family Public Housing - existing units Provincial Portion)	1,617,900
7.	Senior Citizens Public Housing - new (1985)	9,297,600
8.	Family Public Housing - new (1985)	5,968,400
TOTAL		**$27,282,900**

Health

9.	Community Health Services Home Care Nursing	1,240,100
10.	Special Projects (VON Pictou County & Martha Home Health Antigonish County)	63,500
11.	Home Care Services Provided by Hospitals	800,700
12.	Discretionary Grants (VON & Arthritis Society)	625,000
13.	Psychiatric Services - Home Visits	n/a
14.	MSI - Pharmacare	39,400,000
TOTAL		**$42,129,300**

Social Services

15.	Special Social Assistance	10,500,000
16.	Property Tax Rebate	3,020,000
17.	Rental Assistance	1,060,000
18.	Homemakers Services	2,438,800
19.	Expanded Homemakers (Home Life Supports)	330,900
20.	Demonstration Grants (Home Life Supports)	130,300
21.	In Home Supports	593,700
22.	Homemakers Services Administration	67,400
TOTAL		**$18,141,100**

Development

23.	Provincial Employment Program	1,888,000
GRAND TOTAL		**$89,441,300**

All costs are 1985/86 forecast figures, and are before cost-sharing, except where stated otherwise.

EXECUTIVE SUMMARY

Mandate

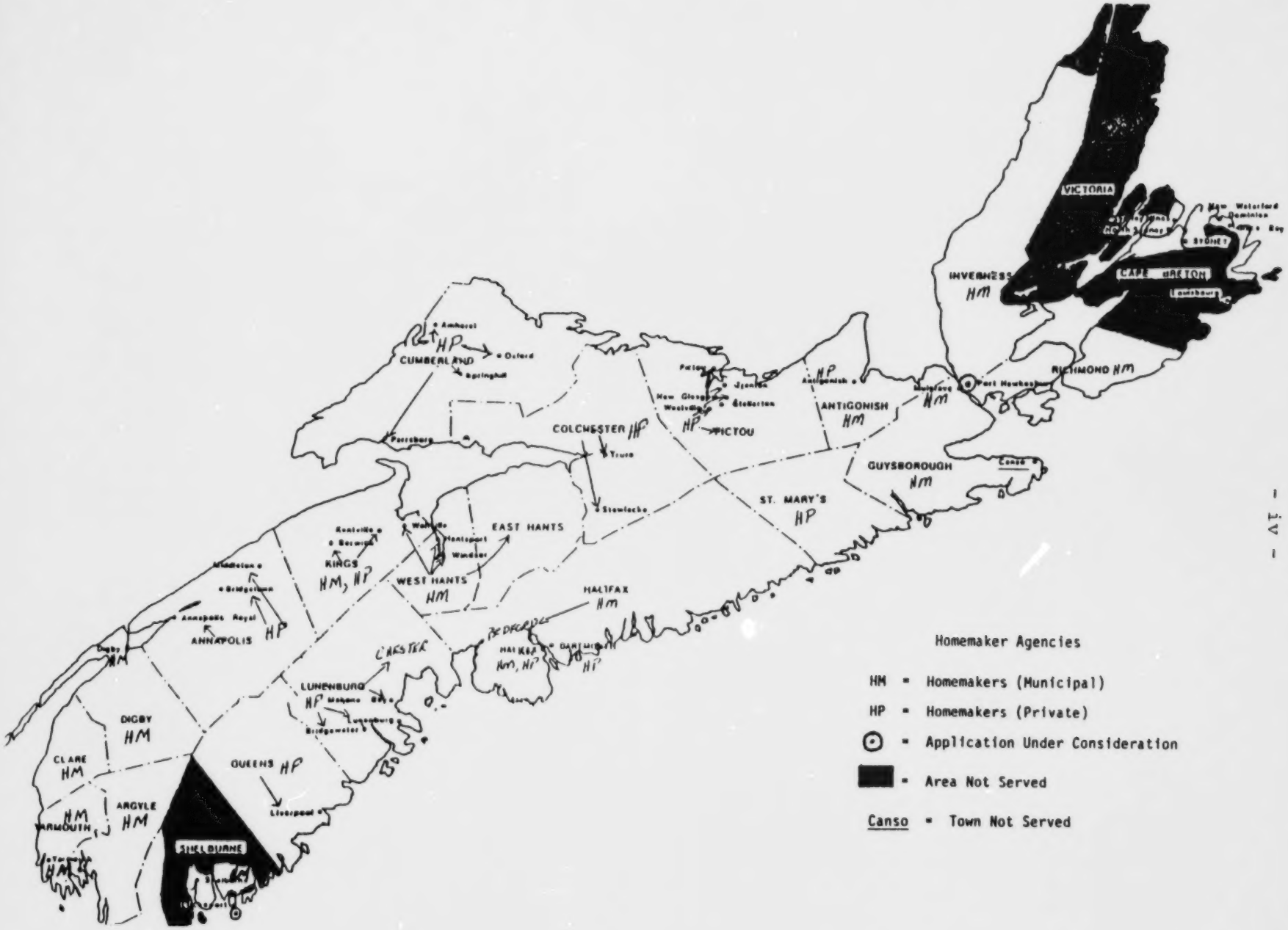
In the Throne Speech of February 27, 1986, the Nova Scotia Government announced that it had designated an interdepartmental committee of the Deputy Ministers of Health, Housing and Social Services to coordinate a comprehensive Home Care Program for Nova Scotia. The Interdepartmental Committee, in association with the Senior Citizens Secretariat and the Senior Citizens Commission, consulted appropriate volunteer, church, community and disabled persons organizations concerning the most suitable coordinated Home Care Program for the Province. The committee also considered research material relating to home care in Nova Scotia and elsewhere in Canada. The following is a summary of the findings along with a recommended design for a coordinated Home Care Program for Nova Scotia.

Existing Home Care Services in Nova Scotia

A number of home care services are currently available throughout Nova Scotia (see Maps):

- Home nursing is available throughout the Province from the Department of Health's Community Health Units and from the Victorian Order of Nurses.
- Homemaker Agencies will soon serve all but five of the Province's sixty-six municipalities. These agencies are partly funded by the Department of Social Services and partly by other sources, including the municipalities.
- Volunteer groups deliver meals-on-wheels, and provide friendly contact and many other services.
- The Department of Housing provides grants that enable people to repair or renovate their homes.
- In Halifax and Dartmouth, the civic governments coordinate home care services chiefly for recipients of Social Assistance.
- Some hospitals provide health services to patients at home.

VICTORIA
INVERNESS
CAPE BRETON
CUMBERLAND
COLCHESTER
PICTOU
ANTIGONISH
GUYSBOROUGH
RICHMOND
ST. MARY'S
EAST HANTS
HALIFAX
ANNAPOLIS
LUNENBURG
QUEENS
DIGBY
CLARE
ARGYLE
YARMOUTH
SHELBURNE
BARRINGTON
COMMUNITY HEALTH SERVICES & VICTORIAN ORDER OF NURSES
CHN = Community Health Nurse
CNA = Certified Nursing Assistant
LN = Liaison Nurse
PT = Physiotherapist (circled = for rural municipalities shown)
Numbers Exclude Supervisors
= Area Served by Victorian Order of Nurses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KINGS
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WEST HANTS
HM
HALIFAX
HM
ANNAPOLIS
HP
DIGBY
HM
CLARE
HM
ARGYLE
HM
YARMOUTH
HM
LUNENBURG
HP
CHESTER
QUEENS HP
SHELBURNE
Homemaker Agencies
HM = Homemakers (Municipal)
HP = Homemakers (Private)
= Application Under Consideration
= Area Not Served
Canso = Town Not Served

Home Care Programs in Other Provinces

Coordinated Home Care Programs exist in all jurisdictions of Canada, except the Yukon. The areas served by the Program may, however, be limited and frequently separate programs serve different client groups in the same province. The range of services offered also varies but usually includes a core of nursing and homemaker services. None of the programs charges for health services. In a number of cases, however, there are charges for homemakers and other services.

What Nova Scotians Say

Consultation with Nova Scotians over the summer and fall of 1986 confirmed that a wide range of home care services currently exist in Nova Scotia. The chief points urged during the consultations were:

- The top priority is the coordination of existing home care services;
- This coordination should be performed at the provincial level by a distinct and highly visible organizational entity;
- There should be a single entry point to apply for service at the local level;
- The program should include assessment and coordination of delivery of homemaking, home nursing, physiotherapy and attendant care;
- The assessment and service delivery functions should be performed by different, not the same, agencies;
- The funding of home care should be primarily a Provincial/Federal responsibility, though some municipal contributions should be expected and individuals in the position to do so should make some contribution to the cost of their non-health care;
- The participation of volunteers in providing services to the Home Care Program is seen as essential, and should be vigorously promoted.

A COORDINATED HOME CARE PROGRAM FOR NOVA SCOTIA

Coordinated home care may be defined as:

> The coordinated delivery of a range of health, housing and social services to meet the needs of persons who require assistance or support in order to remain at home or whose functioning without coordinated home care is likely to deteriorate, making it impossible for the person to stay at home in the community.

In developing the proposed program a number of options were considered. These ranged from a minimal response consisting of the introduction of a single toll-free number and a Province-wide set of standards for service, to the development of a separate home care agency. The structure here recommended by the Deputy Ministers falls between these two in terms of costs and reflects the need for fiscal restraint. It should be noted that experience elsewhere indicates that once a Home Care Program is established, demand for service quickly increases and costs rise accordingly.

The following factors were taken into consideration in developing the proposed coordinated Home Care Program:

- The program should make maximum use of existing services, administrative structures and financial arrangements.
- Coordination should be implemented at three levels - provincially, locally and for each individual case.
- A coordinated Home Care Program should be highly visible and easily accessible to the general public.
- Implementation should begin with the Province-wide provision of a core of nursing and homemaker services with other related services included where available.
- The importance of volunteer services to the program should be recognized and promoted.

Client Group

The Home Care Program would be available to Nova Scotians in need of one or more of the core services, while taking into account the amount of care that can be provided by available resources. As a guideline, the cost in any individual case of providing home care services should not exceed the cost of similar services in an institution. Experience shows that senior citizens and disabled persons are the primary users of home care, with the seniors constituting 60-85 percent of clients.

The minimum number of persons receiving service from a coordinated Home Care Program would be the number currently being served by the separate programs, which would mean that not all the demand for coordinated service would be met. It is not possible to determine the total number of clients served at home by nurses because the statistics available record the total number of visits rather than the total number of persons served. It is estimated that homemakers agencies serve about 3,000 clients.

It has been estimated that the maximum number of persons requiring service would be two percent of the total population. Approximately 8,000 would require nursing services, and 10,400 would require homemakers services.

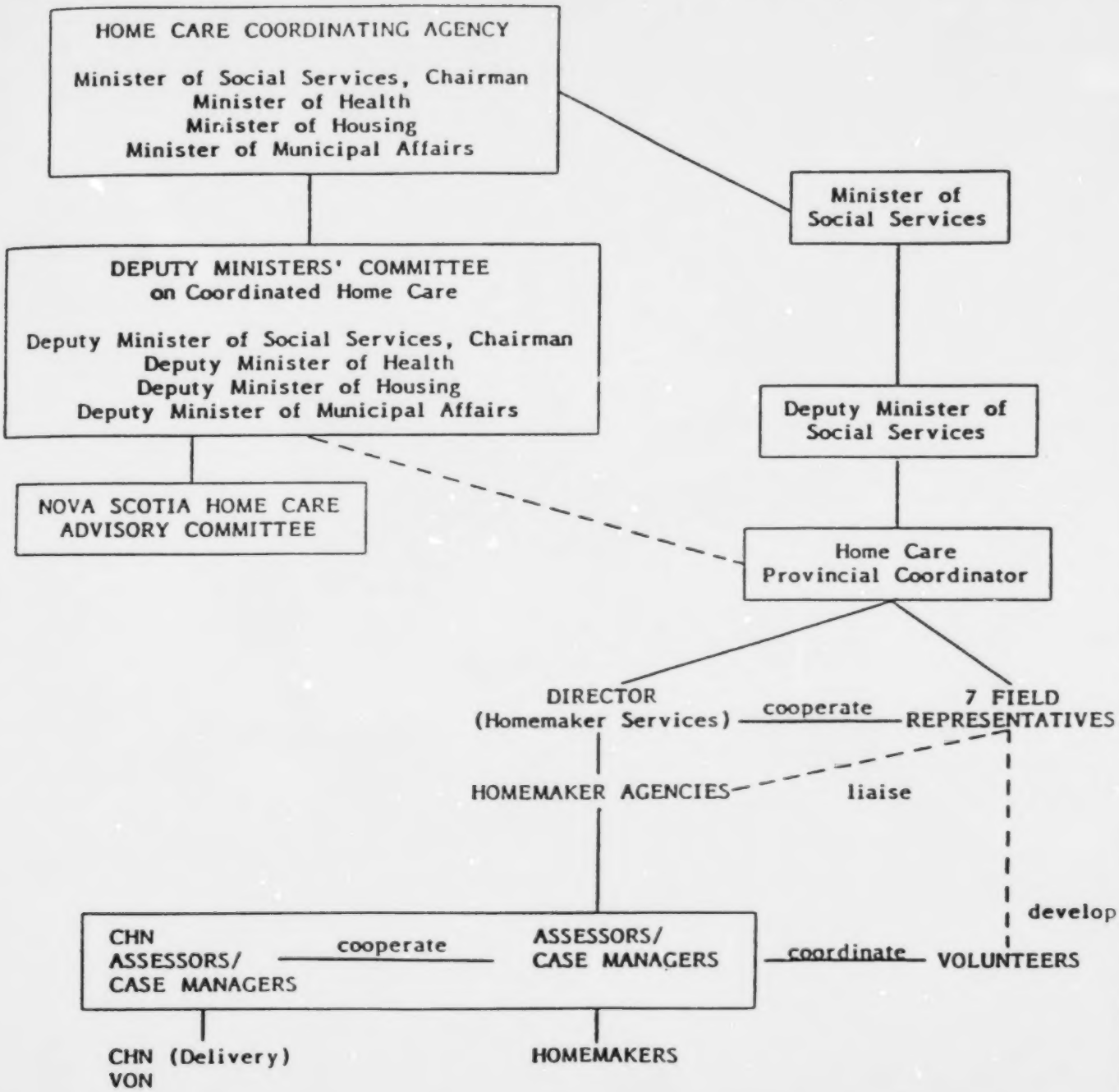
The Administrative Structure

It is recommended that the Home Care Program be delivered through a new Home Care Coordinating Agency comprising the Ministers of Social Services, Health, Housing, Municipal Affairs and other Ministers as necessary, and chaired by the Minister of Social Services. (See attached organization charts). The administration of the program would be the responsibility of the Department of Social Services.

Homemakers agencies would be the principal points of entry to the Home Care Program and would be responsible for coordinating assessments and case management. As well, the homemakers agencies would be responsible for completing the social service assessment. In Halifax and Dartmouth, where more than one agency delivers homemaking services, it is recommended that the municipalities continue to coordinate service delivery. Staff of the Community Health Division of the Department of Health will be involved in completing health assessments throughout the Province and in providing nursing care in those areas of the Province where they now have this responsibility.

Home Care Staff

- Home Care Coordinator (Executive Director level)
- Director of Homemakers Services
- Assistant Coordinator
- Statistical Clerk
- Seven field representatives



COMMUNITY HEALTH NURSES (CHN'S) CONTINUE TO BE TIED TO THE HEALTH SYSTEM.

A Home Care Advisory Committee composed of representatives of professional organizations; homemakers agencies; volunteer groups, e.g., Royal Canadian Legion, churches; client groups, e.g., disabled and seniors; and other interested organizations should be established. This Committee will provide advice to the Deputy Ministers Committee. As well, formal and informal consultation will take place at the local level with agencies, volunteer organizations and groups representing clients of service.

Services

Initially, existing services should be coordinated. These include homemaking, home nursing and volunteer services. The Provincial Coordinator will be responsible for ensuring as a priority that the core services of homemaking and home nursing are available Province-wide by facilitating the development of these services in those areas where they do not currently exist.

Services provided by volunteer groups will be an essential part of the Home Care Program. Volunteers across the Province already provide a variety of services to assist persons who need support to remain in their own homes. The Home Care program will provide opportunities for these services to be coordinated with the other components of the program so as to better meet the needs of individuals requiring service.

Because the availability of volunteer services varies from community to community, the Home Care Program will assist communities to identify service gaps and needs and promote the development of new services as needed. It is essential that the importance of volunteers to the success of a Coordinated Home Care Program be recognized and promoted.

Coordination

(a) Central - This will be the responsibility of the Provincial Coordinator and will involve consultation with other government departments and provincial organizations responsible for services to be included in the Home Care Program.

(b) Local - Responsibility for local coordination will be divided between the Provincial Coordinator acting through the field representatives and the homemakers agencies. In those communities where there is not already coordination, the field representatives will be responsible for identifying services to be included in the Home Care Program and making arrangements for the providers of these services to work cooperatively with the program. The field representatives will also be responsible for working with communities to develop new services where needed. Responsibility for coordination

will remain with the homemakers agencies in those communities where those agencies are already working closely with other community agencies.

(c) Case - Homemakers agencies will be responsible for identifying, coordinating and monitoring services for individual clients. These agencies will be the primary point of entry to the Home Care Program and will be responsible for completing the social service assessment. Where a health assessment is required, referral will be made to the Community Health Nurses in the area, and the two services will work cooperatively in developing a case plan and coordinating services.

Funding

The budget of the Home Care Coordinating Agency should include funds required for homemaking and home nursing services. There will be no change in the funding arrangements for homemakers agencies. Agencies would continue to receive a grant based upon the formula currently used. The cost of health assessments, to be completed by the Community Health Nurses, will be funded by the Department of Health. The cost of the nursing service provided by the Community Health Nurses will be paid by the Home Care Agency administration through a charge-back. Similarly, the cost of nursing care provided by other nursing agencies, such as the VON or Comcare, will be paid by the Home Care Division.

Health services should be provided free of charge but clients should contribute toward the cost of homemaker services according to a scale based on income and family size. The fee schedule should be developed in cooperation with the homemakers agencies and to meet the requirements of Canada Assistance Plan for Federal cost-sharing.

Costs

Two estimates of costs, based on minimum and maximum caseloads, have been completed. The minimum increase in costs of 2.4 M reflects no expansion of service except the extention of homemakers services into those areas of the Province where they do not now exist. The maximum increase of 9.1 M is based on the cost of providing service to a client group comparable in size to that in other provinces. The actual initial increase will probably fall somewhere between the minimum and maximum.

Implementation

It is essential that sufficient time be allowed for implementation of the Program. The Provincial Coordinator and field representatives should have at least a year to arrange for coordination of services, negotiate with agencies whose services are to be included in the program, and resolve the numerous issues which will arise during this process. During this time, existing services would continue to be delivered as they are now and homemakers services would be extended to those areas not currently served. The additional cost during the first full year of operation we estimate would be $867,000 gross, $758,500 net. The following are some but not necessarily all of the tasks which must be undertaken:

- Identify all available services which are to be included in the program in each area of the Province and begin discussions with agencies, municipalities, hospitals, volunteers and groups responsible to gain their cooperation;

- Negotiate with homemakers agencies regarding their role in the Home Care Program;

- Negotiate with the Department of Health for the provision of nursing services in those areas of the Province to be served by them;

- Negotiate with municipalities concerning their continued participation in the funding and in many instances the delivery of homemakers services;

- With the assistance of the Department of Health, negotiate with VON, Comcare, etc., concerning levels of service and rates of remuneration in those areas of the Province served by such agencies other than the Department of Health;

- Develop homemakers agencies or make other arrangements for the provision of nomemakers services in those areas of the Province where these do not currently exist;

- Develop policies, standards and procedures in consultation with the relevant agencies to ensure that standardized services are available Province-wide;

- Design procedures and forms for assessment;

- Develop a fee structure for appropriate clients for homemaker service components of the Home Care Program, in cooperation with the homemakers agencies.

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PART I

BACKGROUND

I. INTRODUCTION

Mandate

In the Throne Speech of February 27, 1986, the Government announced its intention to proceed with new initiatives in home care:

> My Government already provides significant health and non-health services to senior citizens and disabled Nova Scotians in their homes. My Government has designated an inter-departmental committee composed of the Deputy Ministers of Health, Housing and Social Services to coordinate a comprehensive home care program for Nova Scotians. This committee will further involve the Senior Citizens' Secretariat, the Senior Citizens' Commission, and appropriate volunteer, church, community and disabled persons organizations. The committee will report to Government at the earliest appropriate date.

Early in March the interdepartmental committee of Deputy Ministers established a staff committee representative of Health, Housing, Social Services and Policy Board to research and document home care services in Nova Scotia, the other Provinces and the Territories for the purpose of determining the home care services now available in Nova Scotia, their distribution and accessibility, and how home care in Nova Scotia compares with similar services in other Provinces and the Territories.

As well, the Deputy Ministers Committee, with the assistance of the Senior Citizens' Secretariat and the Senior Citizens' Commission, arranged for and attended a series of community consultations during the months of August, September and October. At meetings in thirteen locations throughout the province the consultations committee met with approximately 300 local and provincial organizations and concerned citizens whose primary interest lay in ensuring the provision of an adequate home care program for seniors, the disabled and families ar risk.

The purpose of this report is

a) to summarize the research carried out by the officials committee into home care services in Nova Scotia, the other Provinces and Territories;

b) to detail the major findings of the community consultations, which focused not only on what now exists by way of home care services but also on how the community feels about what needs to be done to make these services more effective and what is required in the way of new services;

c) to consider the options open to the Government of Nova Scotia with respect to administrative structures and types of service for a coordinated home care program;

d) to recommend the administrative structure and types of service best suited to a coordinated home care program in Nova Scotia.

Background

The development of a Home Care Program for Nova Scotians is a primary social policy goal of the Government of Nova Scotia.

In support of this social policy goal, the Departments of Health, Housing and Social Services spent approximately $80 million on 22 programs related directly or indirectly to home care in 1985-86. These programs included Rental Assistance, Property Tax Rebates, Seniors' Special Assistance, Homemakers, Home Life Supports, In-Home Supports, Home Care Nursing, the Victorian Order of Nurses, the Arthritis Society, Pharmacare, the Senior Citizens Assistance Program, the Provincial Housing Emergency Repair Program, and the Senior Citizens Subsidized Housing.

A number of these programs such as Rental Assistance Home Life Supports, In-Home Supports and the Senior Citizens Assistance Program, were introduced by the Provincial Government during the past decade.

Others, such as Homemakers and Pharmacare, have been expanded substantially in response to a growing need. Provincial expenditures on Homemakers increased thirty-five fold from $68 thousand in 1978-79 to $2.4 million in 1985-86. Similarly provincial expenditures on Pharmacare grew by 200% from $14.5 million in 1978-79 to $39.4 million in 1985-86 and are expected to reach $44.9 million in 1986-87.

In June of 1984 the Province hosted a major Nova Scotia Conference on Aging and the Aged entitled, "Seniors Helping Seniors" for 336 participants; including 234 seniors. At least three of the Conference Workshops focused almost exclusively on home care, what has been accomplished to date, and what needs to be done to effect a home care program which would give seniors "the option of remaining in their homes for as long as they wish and are able to do so."

The Medical Society of Nova Scotia in its recent report entitled Physicians for Home Care noted that "We are closer to a coordinated home care programs in Nova Scotia than is apparent. Many services for helping sick or disabled persons to recover or be maintained at home already exist."

II. EXISTING HOME CARE SERVICES IN NOVA SCOTIA

Health, Housing and Social Services are the principal departments whose services and programs enable the elderly, ill and disabled to remain in their own homes rather than seek institutional care (see Table 1). Some of these programs and services are delivered directly by the Provincial Departments, others indirectly through the municipalities and private agencies.

In-home nursing services provided by Community Health Nurses or the Victorian Order of Nurses (VON) are available in all parts of the Province. Similarly, citizens in all parts of the Province can benefit from the Department of Housing programs that enable people to stay in their own homes. Social Services direct assistance programs, such as Special Social Assistance, Property Tax Rebate and Rental Assistance, are available to citizens in receipt of various Federal income supplements. Indirect assistance programs, which are delivered by the municipalities and cost-shared by the Department of Social Services are not available in all municipalities. In-home supports are provided by only 32 of the 66 municipal units. Homemaking agencies exist in all but five units (and do not fully operate in a sixth).

Home care programs in other Provinces typically rely on voluntary agencies to provide some of the support services that are essential to enable home care to serve the largest possible number of clients. Meals on Wheels, for instance, are commonly delivered by volunteers. In Nova Scotia, voluntary agencies already provide some services that would naturally form part of a homecare program, but these services are found in fewer communities than are the services provided by the Province and municipalities.

Services provided by the Department of Health

Home nursing care is provided mainly by the Department of Health, though the Community Health Nurses (CHNs) and Certified Nursing Assistants (CNAs) and by the Victorian Order of Nurses (VON).

There are about 150 Community Health Nurses and 50 Certified Nursing Assistants in 60 locations throughout the Province (see Map 1). There is a general understanding between the Department of Health and the VON that the Community Health Nurses will not provide home nursing care in those areas served by the VON (see Map 2), and vice-versa, though there are cross referrals if necessary. Elsewhere, the CHNs add home nursing care to their preventative and educative responsibilities. On average, CHNs and CNAs spend 17% and 23.3%,

TABLE 1: PROVINCIAL EXPENDITURES ON HOME CARE-RELATED PROGRAMS, 1985-86

Housing	
1. Senior Citizens Assistance	$ 5,712,000
2. Provincial Housing-Emergency Repair	800,000
3. Small Loans Assistance	750,000
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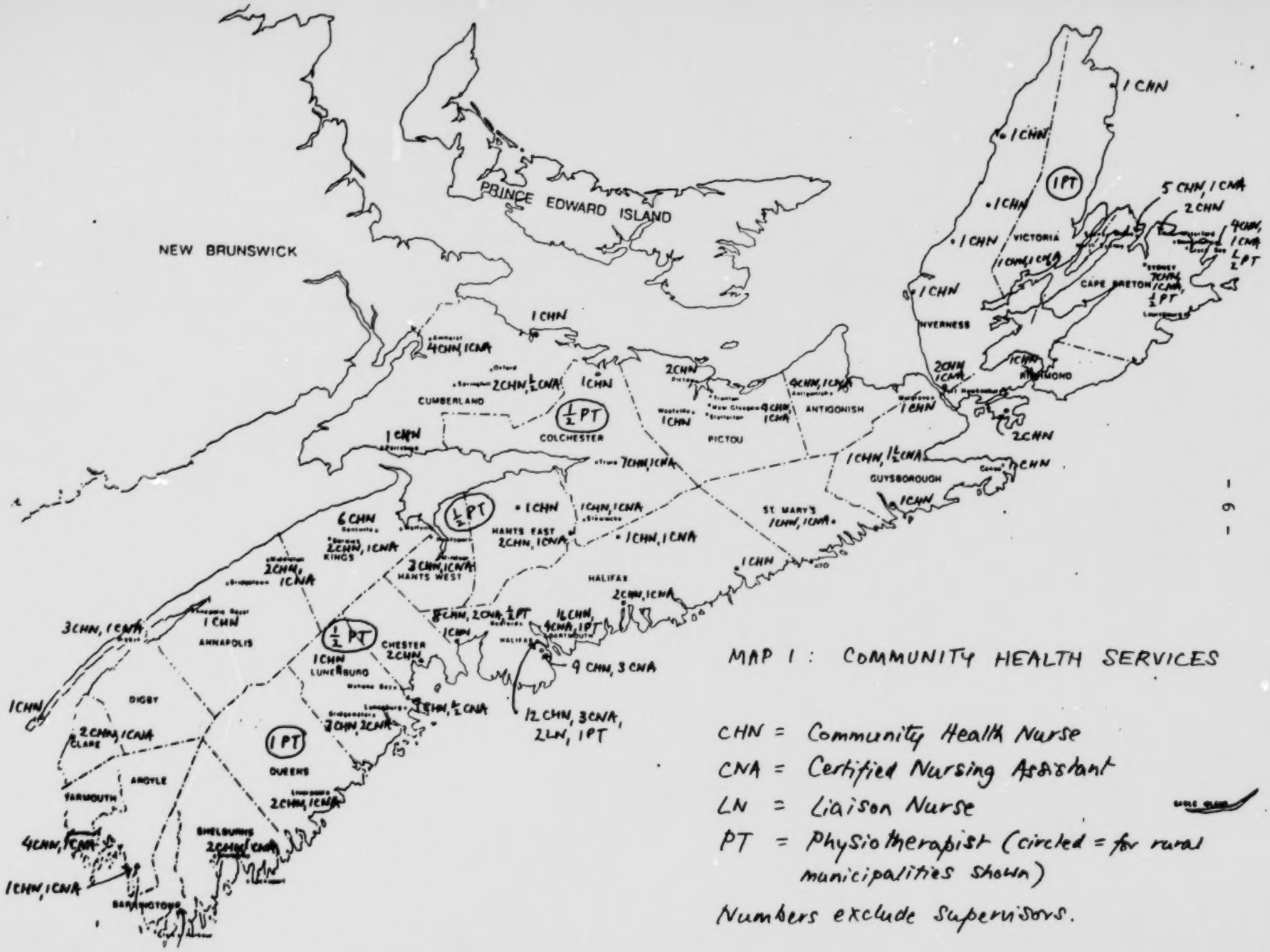
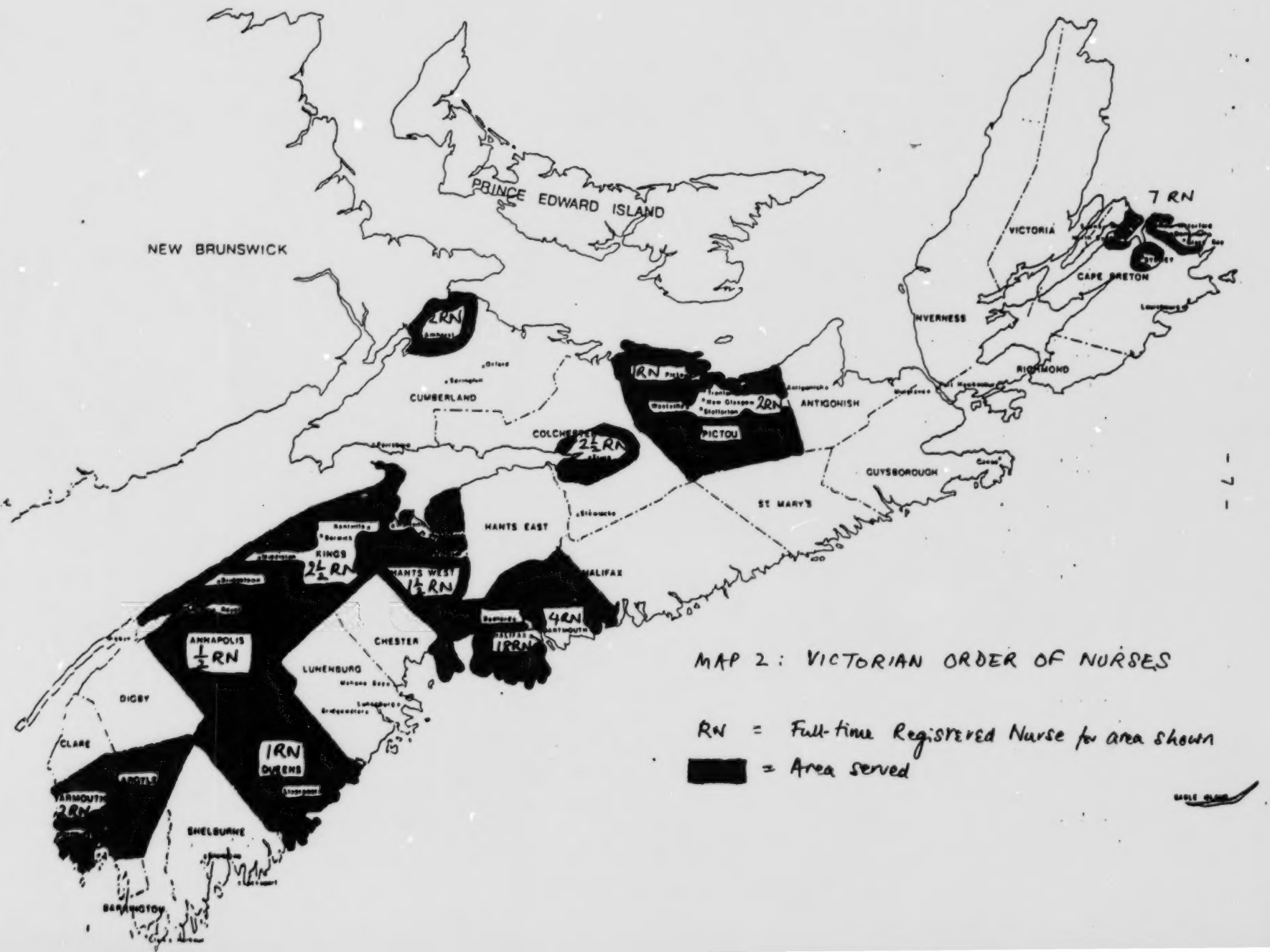


MAP 1 : COMMUNITY HEALTH SERVICES

CHN = Community Health Nurse
CNA = Certified Nursing Assistant
LN = Liaison Nurse
PT = Physiotherapist (circled = for rural municipalities shown)

Numbers exclude Supervisors.



MAP 2: VICTORIAN ORDER OF NURSES

RN = Full-time Registered Nurse for area shown

■ = Area served

respectively, of their time on home nursing care (exclusive of travel and administrative time). The Department has hired five half-time casual CNAs to provide home nursing care under CHN supervision in high demand areas (Springhill, Lunenburg Town, Guysborough Town and Sherbrooke). Generally speaking, the required level of service defined by the Department of Health for home nursing care is lower than that defined by the VON. The Department estimates that about 60% of all home nursing care services can be provided adequately by CNAs.

The Victorian Order of Nurses has 42 full-time, 4 regular part-time and about 40 casual part-time nurses in 12 branches in various parts of the Province. The Dartmouth Branch has introduced a new level of health worker, the Home Care Aide, and there are plans to introduce four in Argyle.

The VON provides home nursing care in areas inhabited by 62% of the population. The remainder of the province is served by the Department of Health (see Maps 2 and 3).

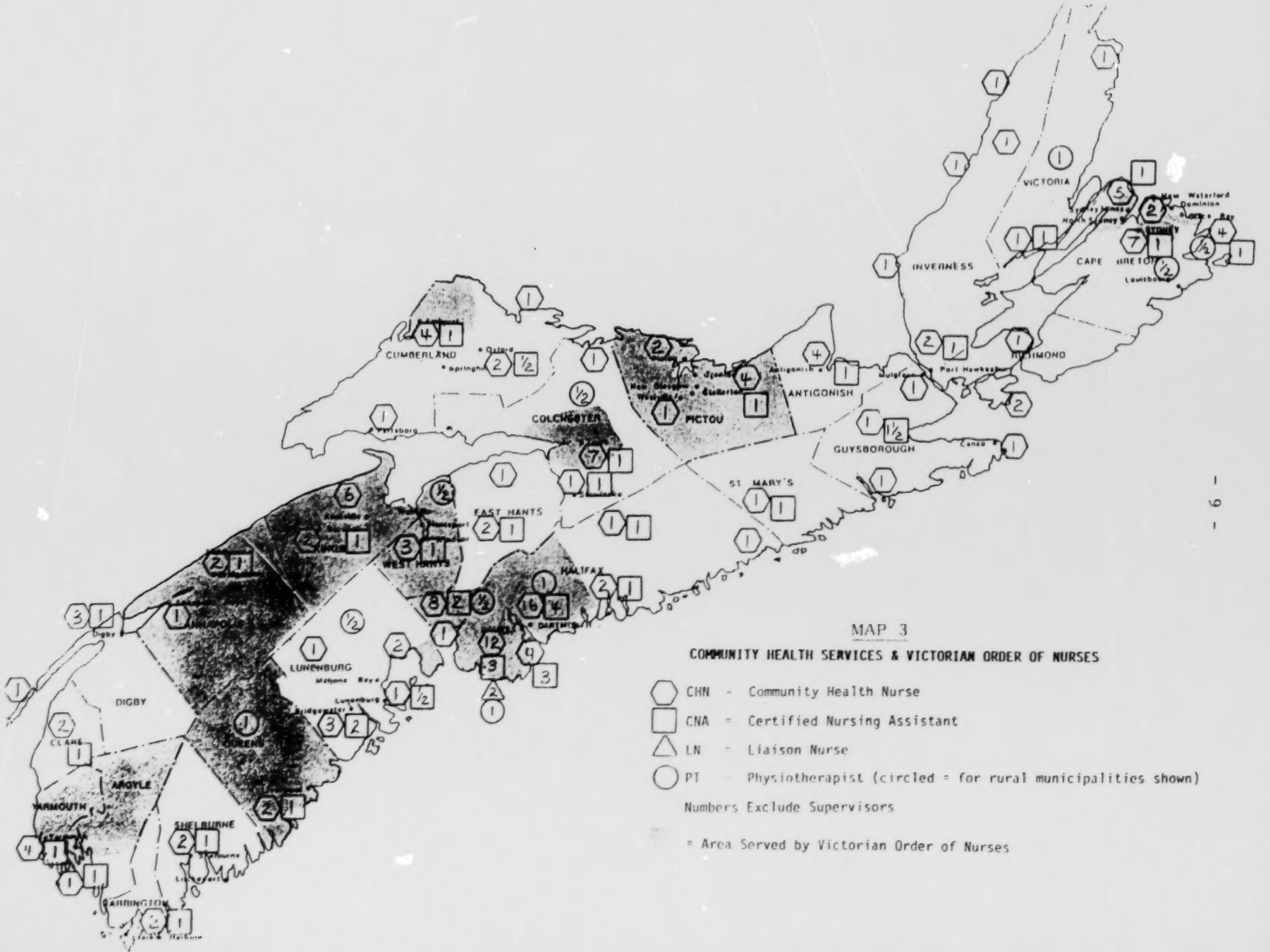
Where the CHNs are responsible for home nursing, they provide this service free of charge.

The VON charges a fee of approximately $26 per visit, but this fee many be reduced or waived as financial or family circumstances warrant. In 1985, 25% of visits were paid for in full, while about 69% of visits involved partial payment and 6% no payment. Partial payment would appear to have been substantial, for the VON obtained 50% of its revenue from fees. Twenty-five per cent comes from United Way fund raising, 18% from the Province and 7% from municipal grants.

The cost of providing home nursing care, including psychiatric follow-up, through Community Health in 1985/86 was about $1,240,000.

The total cost of the VON's services for 1985-86 was $2,020,000. Of this sum $400,000 came from the Provincial Government as a discretionary grant. (The annual grant is $285,000; in 1985-86 there was an extra grant of $115,000.) The Province also paid the VON $28,792 for VON services in West Pictou County.

In discharging patients who require nursing care at home, hospital discharge planners contact either the Community Health Nurses or the VON, depending upon where the patient lives. The nurses perform the health care required by the discharging physician, liaise with the patient's physician, and may assess the patient by visit if necessary. There is no requirement for the nurse to



MAP 3

COMMUNITY HEALTH SERVICES & VICTORIAN ORDER OF NURSES

- CHN - Community Health Nurse
- CNA = Certified Nursing Assistant
- LN - Liaison Nurse
- PT - Physiotherapist (circled = for rural municipalities shown)

Numbers Exclude Supervisors

= Area Served by Victorian Order of Nurses

contact the local homemakers or other care providers if their services are required, though many nurses probably do so.

The Department of Health funds two pilot projects on home nursing care. The Martha Home Health Project, covering all of Antigonish County, serves patients 60 years old and over during week days only. Department of Health CHNs provide patient care on weekends, leading to expenses on overtime for the Department and scheduling problems. The Department pays Martha Home Health $16 per nursing visit and $10 for a visit by a nursing assistant. An optional $2 per visit fee is charged. The total cost of the program in 1985 was $134,323, of which the Province granted $25,000 and 2% of the total was recovered in fees.

There is also a pilot project serving patients 60 years of age and over in western Pictou County where the Department pays the VON a flat rate of $17 per visit to provide home nursing services in that area. The treatment provided by the VON is monitored closely by Community Health nursing staff. The money paid to the VON under this agreement amounted to $28,792; this sum is over and above the Provincial Grant to the VON.

There is no definitive policy for the provision of home care services by hospitals in the Province. Rather, hospitals have developed such services where a need or demand for service exists and the hospital is both prepared to provide the service and able to work out funding arrangements with the Department of Health. Patients may gain access to the in-home services by contacting hospital administration staff. About $800,000 was spent in 1985-86 on home care services provided through the hospitals. The funds are made available indirectly through general operating grants from the Department of Health. Most of this service in the form of equipment loans, such as oxygen concentrators and ventilators.

The Department of Health pays an annual grant ($225,000 in 1985-86) to the Arthritis Society to provide home physiotherapy in various areas of the Province. This service is provided on the basis of a medical referral. Although in theory available to all sectors of the population, the service is not available in all areas owing to a shortage of physiotherapists and a lack of funds. At present there are only 5.5 physio-therapists delivering this home care service; 11.5 more would be required to bring Nova Scotia up to the Canadian average of one home-care physiotherapist per 50,000 population. The Society's home care budget in 1985 was some

$265,000, most of which came from the Department of Health, though 7.2% of the revenue was raised in fees. The fee for service is $25 per hour, adjustable according to the client's ability to pay. The Society estimates that a full home physiotherapy program would cost $700,000 per year in 1986 funds.

In 1986 staff from mental health centres made 2,585 home visits. These visits were not made in order to establish a home visiting program, but for other reasons, such as treatment of patients too ill to leave home and inspection of a patients home environment. The Community Health Nurses, however, do provide in-home psychiatric care as part of their home nursing care. In 1985 they provided 6,647 psychiatric nursing cares throughout the Province, which took up 1.8% of thei total time and 10.5% of their total home nursing time. The expenditure on psychiatric cares was $64,488 in 1985. The Nova Scotia Hospital provides informal day care facilities for 150 to 220 patients in the Halifax metropolitan area.

Programs providing prescribed medication free of charge to home care clients are a feature of a few home care programs in other jurisdictions. In Nova Scotia, Pharmacare is available to all senior citizens aged 65 or over who are registered under the MSI program. Pharmacare is a prescription drug insurance program which provides payment toward the cost of those preparations which are normally prescribed by a doctor or dentist in the course of treatment and are dispensed by a pharmacist. The 1985-86 forecast cost for this program is $39,400,000.

Services provided by the Department of Housing

Housing programs are essential to enable people receiving in-home services from the Departments of Health and Social Services to remain in their own homes.

Home care programs in other provinces sometimes include a handyman or home maintenance component. The Department of Housing programs most closely related to this aspect of home care are wholly provincially financed. They are as follows (costs for 1985-86 based on initial budgets):

Provincially financed

Senior Citizens Assistance Program (home repair)	$5,712,000
Provincial Housing Emergency Repair Program	800,000

Small Loans Assistance Program (home repair and rehabilitation)	750,000
Access-a-Home (structural changes)	115,000
	$7,377,000

While subsidized housing programs are not part of home care programs in other provinces, they do allow people to stay in the community. Department of Housing programs providing low cost housing for lower income groups are cost shared with the Canada Mortgage and Housing Corporation and the municipalities (see Table 2).
The provincially financed home-repair programs are delivered by the Department's four regional offices at Bedford, Middleton, New Glasgow and Sydney, and from district offices in Amherst and Liverpool.

i) The **Senior Citizens Assistance Program** helps senior citizens carry out needed repairs and alterations to their homes so that they can continue to live in them. Under the program, the Department offers seniors a forgivable loan of up to $3,000 for home repair work. To qualify, the taxable income of the household of which a senior citizen is head must be less than $13,000 p.a. The borrower must undertake to stay in the house for at least three years following the repairs. The loan is written off at the end of three years.

ii) The **Provincial Housing Emergency Repair Program** provides grants of up to $2,500 to homeowners of any age who need to make crucial repairs to their homes but cannot afford to do so. To be eligible, the homeowner's income must be less than $6,000 p.a. and the homeowner cannot be eligible for assistance under any other Federal, Provincial or Municipal rehabilitation program.

iii) The **Small Loans Assistance Program** offers homeowners low interest loans so that they may make alterations or have work done in and around their properties. The maximum amount available is $5,000, depending on the applicant's ability to pay and the cost of the work to be done. To be eligible, the gross household income must be less than $17,000 p.a. The interest rate varies according to the applicant's income; the loan is repayable over five years; and a first or second mortgage is taken as security.

iv) The **Access-a-Home Program** offers financial assistance to persons confined to a wheelchair who wish to modify their home to make it more convenient, accessible. The grant covers a percentage of the costs of alternations such as installation of ramps, lowering door handles, widening doors and elimination of irregularities in floors. To be eligible, at least one member of the household must be confined to a wheelchair. If the

TABLE 2: FEDERAL/PROVINCIAL COST-SHARED PROGRAMS, DEPARTMENT OF HOUSING, 1985-86

	CMHC	Provincial	Municipal	Total
Senior Citizens Rent-to-Income Housing				
- subsidies for existing units	12,793,348	3,022,025	2,196,173	18,011,546
- new construction, capital costs (198 units)	6,973,187	2,324,396	-	9,297,583
	19,766,535	5,346,421	2,196,173	27,309,129
Family Rent-to-Income Housing				
- subsidies for existing units	8,009,921	1,617,880	1,348,154	10,975,955
- new construction, capital costs (93 units)	4,476,266	1,492,089	-	5,968,355
	12,486,187	3,109,969	1,348,154	16,944,310
Total cost-sharing				
- subsidies	20,803,269	4,639,905	3,544,327	28,987,501
- new construction	11,449,453	3,816,485	-	15,265,938
	32,252,722	8,456,390	3,544,327	44,253,439

- In 1985, construction capital costs were shared 75:25 Federal: Provincial as were most subsidies, except for some subsidies dating from previous years when there was 50:50 cost-sharing.

- There are 6895 senior citizens rent-to-income units in Nova Scotia (December 31, 1986).

Services provided by the Department of Social Services, municipalities and community agencies

The Department of Social Services provides financial assistance directly to seniors. Such assistance is not usually associated with home care programs in other provinces. In addition, the Department provides the major portion of funding for home support services that are considered part of home care elsewhere. These services, which are also funded by the municipalities and the United Way, are delivered by the municipalities and community agencies.

Assistance programs fully funded and delivered by Department of Social Services

Special Social Assistance	$10,500,000
Property Tax Rebate	3,020,000
Rental Assistance	1,060,000
	$14,580,000

Service Programs funded by Department of Social Services

Homemakers Services	$ 2,837,100
Demonstration Grants	130,300
In-home Supports	593,700
	$ 3,561,100

The Department also funds meals on wheels services in several areas.

The Assistance Programs funded and delivered by the Department of Social Services consist of financial assistance to seniors under the Senior Citizens Financial Aid Act, 1981. The intent of this Act is to provide assistance to seniors so that they may remain in their own homes for as long a time as possible (see Table 3).

a) **Special Social Assistance** provides an annual payment of from $109 to $219 to senior citizens who receive the Federal Guaranteed Income Supplement (GIS). Approximately 56,000 seniors received this benefit in 1985. Some of these people live in their own homes, some in subsidized senior citizens housing, some in homes for special care. Application forms for this benefit are mailed by the Department of Social Services to all persons receiving GIS in the Province.

TABLE 3: SENIOR CITIZENS FINANCIAL AID PROGRAM

DEPARTMENT OF SOCIAL SERVICES

Seniors Social Assistance

Fiscal Year	No. of Recipients	Total Payments
1977-78	48,948	$ 6,492,520
1978-79	51,827	6,754,155
1979-80	52,800	7,504,742
1980-81	53,409	8,144,045
1981-82	54,432	9,281,113
1982-83	56,286	10,556,581
1983-84	56,616	10,449,038
1984-85	57,170	10,444,662
1985-86	58,302	10,543,147
1986-Oct. 87	57,782	10,354,898

Property Tax Rebate

Fiscal Year	No. of Recipients	Total Payments
1980-81	21,074	$ 2,167,850
1981-82	21,297	2,405,474
1982-83	20,135	2,690,441
1983-84	18,967	2,624,530
1984-85	18,600	2,694,006
1985-86	19,130	3,001,237
1986-Oct. 87	18,826	3,098,350

Rental Assistance

Fiscal Year	No. of Recipients at March 31	Total Payments
1981-82	1,789	$ 902,221
1982-83	1,650	940,008
1983-84	1,600	1,083,174
1984-85	1,950	1,211,327
1985-86	1,830	1,036,366
1986-Oct. 87	1,700	624,000

Note: 1986-87 figures for special Social Assistance and Property Tax Rebate may be revised, as further claims for this benefit are received.

b) The **Property Tax Rebate** provides an annual rebate of 50% of the previous year's property taxes. Those eligible are senior citizens who own and live in their own homes and receive the Guaranteed Income Supplement or the Spouse's Allowance paid under the Federal Old Age Security Act. In 1985-86 about 18,900 people received this benefit. People who indicate on their Special Social Assistance application that they own their own house are sent an application form for the Tax Rebate, as are people who have been on the previous year's list of recipients of this benefit.

c) The **Rental Assistance Program** provides a monthly rental supplement to senior citizens whose monthly rent is greater than 30% of monthly income. To be eligible the senior citizen must be in receipt of GIS or the Spouse's Allowance or be single and have an annual income not greater than $9,800. About 1,830 seniors received this benefit in 1985. Maximum rent amounts are used for single people and for married couples when determining the level of a rental assistance payment.

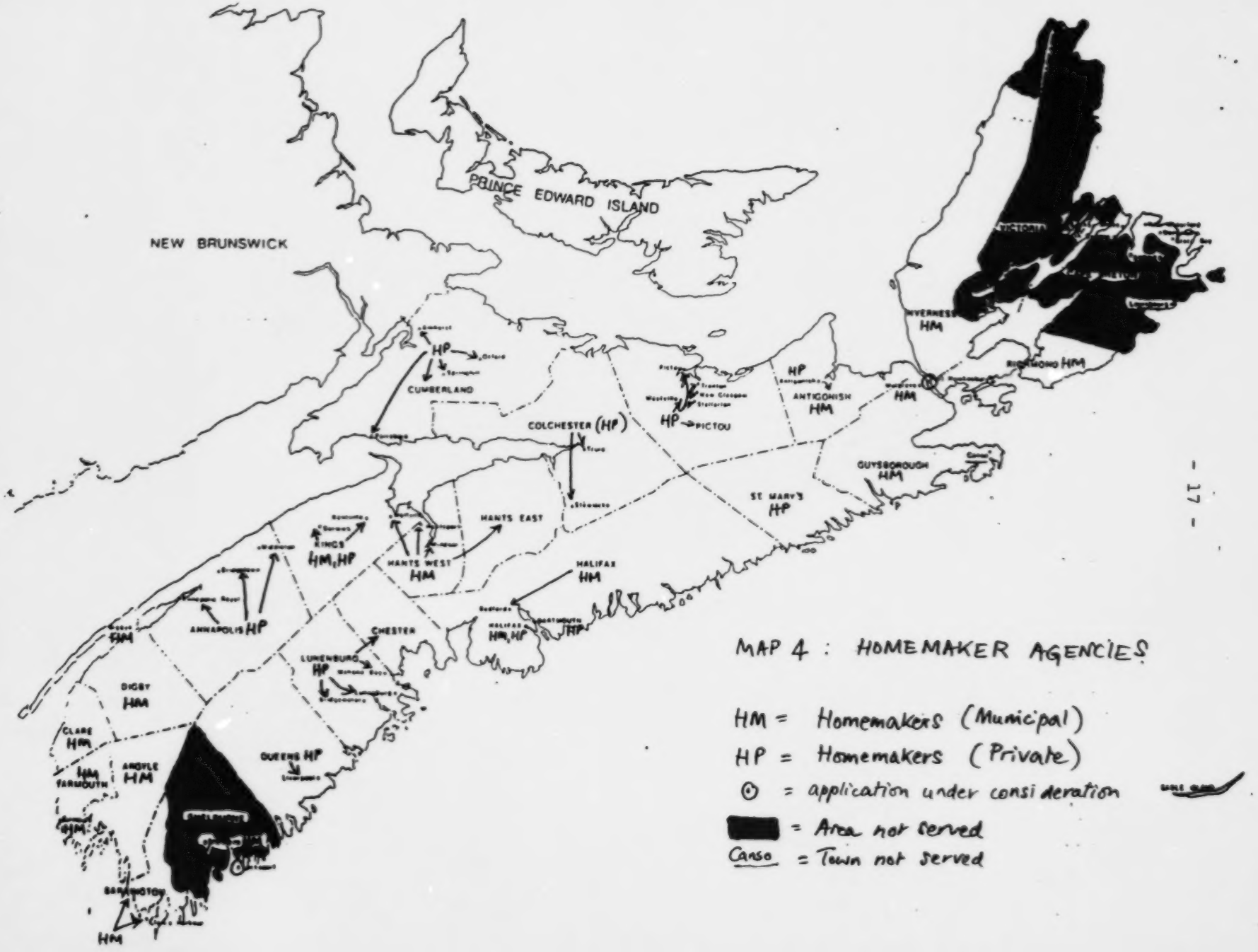
The latest figures for a Provincial claim for recoveries from the Federal Government on programs under the Senior Citizens Financial Aid Act are for 1984-85. In that year, the province spent $14,349,995, and expects recoveries of about $460,000 from the Canada Assistance Plan (CAP). This claim must still be adjusted. Consequently the province spent $13,889,995 of its own funds on this program. The low level of recoveries is due to the small number of recipients of this benefit who, when their assets and expenditures are taken into account, are deemed to be in need, according to the CAP definition.

d) **Homemakers Services** are available through a variety of sponsors in the Province. To be eligible for funding from the Department of Social Services, a homemaking program must be operated by a municipal unit, a Children's Aid Society, or a non-profit organization incorporated under the Societies Act. The agency must, furthermore, comply with the provisions of the Homemakers Services Act, 1982. Clients seeking service must be needs tested.

At present there are 37 homemaking agencies, operating in all municipalities except Victoria County, rural Cape Breton County and the District of Shelburne. These agencies employ 229 full-time homemakers. (See Map 4).

An agency may provide services to families or individuals to assist them in

a) the care of children
b) maintaining good housekeeping standards



MAP 4 : HOMEMAKER AGENCIES

HM = Homemakers (Municipal)

HP = Homemakers (Private)

⊙ = application under consideration

■ = Area not served

Canso = Town not served

c) the preparation of meals
d) managing income and expenses
e) the development of parenting skills, and
f) the maintenance of personal hygiene and grooming.

Homemakers are not allowed to provide services normally provided by medical personnel, such as physicians, nurses or physiotherapists. The range of services provided by agencies varies, but generally does not include heavy household chores, which may be interpreted by some agencies to include washing the ceiling or walls or what is generally known as seasonal cleaning. Certain agencies specialize in work with families at risk or in the children's aid field; these agencies stress teaching homemaking skills to their clients.

The Department provides a percentage of the funding of approved homemakers agencies. The percentage ranges from 75% to 93% of the approved budget, according to the formula used for cost-sharing general assistance in each municipality (the old Education Foundation Scale). The remainder is made up by municipal grants, private fund raising and fees (where charged).

Nominal fees for service are charged, particularly by the non-municipal homemakers agencies, as a way of raising funds. Services are not, however, denied if a client cannot pay the nominal fee (e.g. $2 per visit).

e) A component of the **Home Life Supports Program**, introduced in 1984, provided funding to homemaker agencies interested in expanding and adding to their traditional services. Additional services could include home handyman, snow shovelling, meals on wheels, wheels to meals, adult day care, respite care, attendant care and information and referral services. The sums of money required to operate these services are now included in the grants to agencies.

Persons requiring homemaking services may contact their local agency or be referred to the agency from their municipal social service department, Community Health Nurse, hospital, clergy or other source. In certain areas, people may find service difficult to obtain; some agencies have waiting lists, while others regret that they cannot provide service because demand outstrips budgetary and staff resources.

Of the $2,837,100 spent by the Department on funding homemakers agencies, close to 50% of expenditures, or $1,407,202, are expected to be recovered from CAP in 1985-86. Accordingly the Province is putting $1,429,898 of its own funds into this program.

The **Demonstration Grants** were also part of the Home Life Supports Program. These grants, made in 1984, provided a maximum of $15,000 p.a. to any social service agency undertaking to develop a local, innovative, volunteer or non-profit community organization service directed towards assisting people to remain in their own homes. The grants were to be provided each year for a maximum period of three years, after which the program is to be self-sufficient, not requiring further government funding.

Demonstration grants are eligible for 50-50 CAP cost sharing. Thus of the $130,300 granted in 1985-86, $65,150 were Provincial funds.

The **In-Home Supports Program**, also part of the Home Life Supports Program, made cost sharing available to municipalities who wished to provide financial assistance to families wanting to provide care in the home for an elderly or disabled relative who would otherwise require placement in a home for special care. Thirty-two municipalities applied for cost-sharing under this program which enables the municipalities to make up to $400 p.m. available to qualifying families. Some other municipalities opted not to take advantage of the In-Home Supports program but continue to underwrite similar services through their General Assistance Program. Seventy-five per cent to 93% of municipal General Assistance expenditures are provided by the Province, depending upon the municipality.

In-Home Supports are funded according to the General Assistance Scale. In 1985-86 the Province funded about 26% of General Assistance Expenditures, and the Federal Government, through CAP, about 50%. Therefore, in that year, about $203,108 of Provincial funds were committed to In-Home Supports.

Municipally Coordinated Home Care

The Cities of Halifax and Dartmouth are currently coordinating some fundamental health and social services for persons who can be looked after in their own homes. The Halifax program is directed at Social Assistance recipients; the Dartmouth program also attempts to coordinate services for some people whose income and assets exceed the social assistance guidelines.

In Halifax, a social worker from the Community Care Division assesses a client's needs and then has the authority to contact whatever services are required, and ensure that the services will be paid. The City employs some homemakers, but most services are purchased from homemaking and nursing agencies. Between November 1985 and April 1986, a Community Health Nurse was engaged to

undertake health assessments and arrange for health services to clients at home. This was found to be preferable to the usual arrangement whereby health assessments and the prescription of levels of care wereleft to the actual providers of care, often the VON. In November 1986 the City accordingly reintroduced assessment by a Community Health Nurse as part of its regular assessment process.

As of June 1986, the City was coordinating services for 49 people, at an average cost of $624 per person per month (before cost sharing). This may be compared with the average $1027 per month for the 744 people maintained by the city in homes for special care.

The Dartmouth program, operated by that City's Social Services Department, presents a similar picture. Assessment is undertaken by a community care worker, who coordinates the services. Between January 1 and August 31, 1986, 52 of the 128 persons referred were successfully accommodated within the home care program. The cost to the City, before cost sharing, is $651 per person per month.

Some coordination of services is performed by the municipality of Truro, but the system does not seem to be as formalized as in Halifax and Dartmouth.

III. HOME CARE PROGRAMS IN THE REST OF CANADA

Coordinated home care programs currently are in operation in all the other provinces of Canada as well as the Northwest Territories. This does not mean that in each jurisdiction the programs serve the entire population, nor that the programs are organized from one central office. Programs may be restricted to certain age groups and to certain geographical areas, and there may be several different, unrelated, organizations offering programs in different places in each jurisdiction or else programs for short-term, acute care, patients may have a separate entry point from programs for long-term, chronic care, patients.

Despite the differences, there is a general agreement about the meaning of coordination of services, about the general administrative structure and about the services that are considered essential for a home care program. Whether the program employs its own staff or contracts for services varies, **but no program, anywhere in Canada, could provide an adequate range of services without the help of voluntary agencies and groups.**

From the financial aspect, health services associated with home care are free to the client in all home care programs, but homemaking and other support services frequently charge at least a nominal fee. While a few programs are financed entirely through Established Programs Financing (EPF), most benefit from cost-sharing under the Canada Assistance Plan (CAP) and some have evolved special formulas so that they can avoid income testing but still benefit from CAP cost sharing.

Coordination

Despite the diversity of home care programs in the rest of Canada, there seems to be general agreement on what the word 'coordinated' means with reference to home care services. There are, in fact, three levels of coordination, central, local and personal.

Central coordination means that all home care services within the jurisdiction are delivered according to certain common procedures and standards developed by a central agency. All province-wide programs have a central agency to

- develop policy objectives
- establish procedures and standards
- fund the local units which deliver home care services
- provide staff to advise and assist local units
- gather and analyse statistical data for use in planning and obtaining federal cost sharing.

The central agency responsible for the direction of home care combining both health and social services is, according to the jurisdiction

- Department of Health (Sask, B.C.)
- Department of Health with formal consultative links with Department of Social Services (Ont.)
- Department of Health sharing local offices and payroll with Department of Social Services (Man.)
- Department of Health, with responsibility for Social Services most closely related to home care (Alta, and, insofar as there is provincial input into homecare, Nfld.)
- a single Department of Health and Social Services (P.E.I., N.B., Que.)
- Department of Health and Department of Social Services, in cooperation (N.W.T.)

Agencies coordinating home care programs of social services only, where these are considered to be distinct from the general health and social services home care program, generally report to the Department of Social Services (B.C., Ont.). In New Brunswick, the agency is a separate entity within the Department of Health and Social Services.

Local coordination applies to the local units that arrange for in-home services to be provided to clients. It involves arranging with local organizations or individuals to provide services to individuals whom the local unit has assessed and found to need in-home services. This type of coordination is generally undertaken by the manager of the local unit.

Personal coordination is usually undertaken by the staff of the local unit who are assigned to assess the care needs of applicants. Once the assessment is performed, and the client accepted in the program, the assessor usually becomes the case manager who contacts the care providers whose services are required to enable the client to remain at home. Thus the services are coordinated to meet the client's needs.

Thus the role of the local units is, generally, to provide the local and personal coordination and, more specifically, to

- assess clients following referral
- identify services required
- develop care plans for clients
- provide services or arrange for services to be provided by government departments, non-governmental organizations or volunteers
- reassess clients' condition periodically.

The local units vary from province to province.

- in New Brunswick, the local unit for acute care is the local Service Delivery Unit of the Extra Mural Hospital (EMH) or, where EMH does not exist, the Public Health Unit, which also provides long term care throughout the Province
- in Prince Edward Island, the five regional offices of the Department of Health and Social Services deliver home care
- in Quebec, home care is delivered by 152 centres locaux de services communautaires, autonomous organizations, with their own administrative boards drawn from the community
- in Ontario, there are 38 local Home Care Program Boards. Thirty of these are Municipal Boards of Health, 4 are VON Branches, 3 are Local Hospitals and one is the Incorporated Board for Metropolitan Toronto
- in Manitoba, the units are 8 combined regional offices of the Department of Health and the Department of Social Services, 5 rural health centres and, in Winnipeg, 4 coordinating hospitals
- in Saskatchewan, there are 45 district home care boards, each elected by the members of the district home care corporation. Membership consists of volunteers.
- in Alberta, there are 27 Health Units, equivalent to Boards of Public Health, appointed by local municipalities, school boards and so on. Home care is administered as a separate program by the Chief Executive Officer of the Health Unit and the home care manager.
- in British Columbia, there are 21 Public Health Units (16 Provincial and 5 Municipal, all operating according to the same regulations)
- in the Northwest Territories, there are 4 hospital-based offices with a Territorial Government Nurse designated as home care coordinator
- the St. John's Home Care Program in Newfoundland has a board comprising 5 hospital representatives, 1 representative from the Provincial Department of Health, 1 from the Provincial Department of Social Services, and 3 representatives nominated by the community.

Areas Served

Home care services are available throughout most of British Columbia (94%), Alberta, Manitoba, Ontario, Quebec, New Brunswick and Prince Edward Island.

Home Care programs provide total coverage of densely populated southern Saskatchewan; home care is now being introduced into various communities in Northern Saskatchewan.

In the Northwest Territories, four communities have home care programs.

In Newfoundland, there are a home care program in St. John's and immediate area, and a few hospital-based programs elsewhere.

Delivery of Services

The core services coordinated by home care programs vary from province to province, and indeed from program to program within a province. A general picture of the services considered to be essential is given in Table 4. This shows the services considered to be core in some home care programs in each jurisdiction; in New Brunswick, for example, the core services of the Extra Mural Hospital, Public Health and Community Based Services for seniors are different, but the total services guaranteed to be available somewhere in New Brunswick are shown in the chart.

As can be seen, the absolute minimum of services to be guaranteed by a provincial home care program consists of assessment (and case management), nursing, homemaking and personal care. This is in fact the recognized core of Alberta's home care program; all other services are funded as and where available or are provided by volunteers.

The next most common core services are physiotherapy, meals on wheels and short-term equipment loans. (Equipment loans are in fact available in all jurisdictions through the Red Cross, service agencies or Provincial plans, but they are not always advertised as part of the home care program.)

After these, in six jurisdictions, core services include occupational therapy, handyman (though not necessarily house maintenance) and medical supplies.

Services offered as core in five or fewer jurisdictions include nutritionist, social work, laboratory services, adult day care, drugs, transportation, respiratory and speech therapy.

In most jurisdictions transportation to medical appointments and so on is provided by volunteers. Volunteers normally deliver meals on wheels, even though the service may be guaranteed by the program.

TABLE 4: HOME CARE SERVICES CONSIDERED AS CORE IN SOME HOME CARE PROGRAM IN EACH JURISDICTION, CANADA, 1986

	Alta.	B.C.	Man.	N.B.	Nfld. (St.JHC)	N.W.T.	Ont.	P.E.I.	P.Q.	Sask.	Total
Assessment	-	-	-	-	-	-	-	-	-	-	10
Nursing	-	-	-	-	-	-	-	-	-	-	10
Homemaker	-	-	-	-	-	-	-	-	-	-	10
Personal Care	-	-	-	-	-	-	-	-	-	-	10
Physiotherapy		-	-	-	-		-	-	-		7
Meals on Wheels		-		-		-	-	-	-	-	7
Equipment		-	-	-	-		-	-	-		7
Occ. Therapy			-	-	-		-	-	-		6
Handyman				-	-		-	-	-	-	6
Med. Supplies		-	-	-	-		-		-		6
Nutritionist		-	-	-			-	-			5
Social Work		-	-		-		-		-		5
Lab. Services		-		-	-		-				4
Adult Daycare		-	-	-			-				4
Medication		-		-			-				3
Transportation				-			-		-		3
Resp. Therapy				-				-	-		3
Speech Therapy							-	-	-		3

Services provided by volunteers, and consequently not universally available, include friendly visiting, shopping, running errands, telephone contact, handyman, house and yard maintenance and senior sitting.

Eligibility

Eligibility for home care services varies between the different jurisdictions. Some home care programs will provide health services or home support services (e.g. homemaking, handyman) or both to persons of all ages. This occurs in the Northwest Territories, Saskatchewan, Manitoba, Quebec and Prince Edward Island.

In the other provinces, acceptance for home care depends on the applicant's age and medical status. In British Columbia, Alberta, Ontario, New Brunswick and St. John's, Newfoundland, applicants must be over 65 to qualify for receiving home support services separately from health services. All ages qualify for combined health and home support home care provided they can show medical need.

Some programs divide home health care into acute and chronic care components, with distinct qualifying criteria. In British Columbia, acute care is available to all, but chronic care only to over 65s and the disabled over 19. The situation is similar in New Brunswick, but while there is no time limit for acute care in British Columbia, there is a limit of about 30 days for home care provided by New Brunswick Public Health (though not by Extra Mural Hospital). In Ontario and St. John's, Newfoundland, all ages are eligible for both acute and chronic care, but the levels of funded service provided are different.

Referral by a physician is required for admission to Home Care programs in Ontario (though not to Home Support and Integrated Homemakers in that Province). Likewise, in the Northwest Territories, referral by a health care professional is required. Elsewhere, most programs accept referrals from any source, but require a physician's authorization or referral for the provision of health services. Thus clients themselves may apply for home care, but a physician's authorization must be obtained (frequently by home care staff) in order for health services to be provided. Only Manitoba and Saskatchewan do not require a physician's referral.

Usually the partient must be covered by the Provincial or Territorial health care plan to be accepted for health services. Since the health care plan usually involves residency, this is an implicit residency requirement. Prince Edward Island, Manitoba and the Home Nursing Program in British Columbia have no residency requirements, while Long Term Care in British Columbia has a residency requirement of 12 months.

Certain eligibility requirements are common to all programs. They are

- the home must be suitable for the provision of care
- the ailments can be treated at home, out-patient care being unsuitable.

In St. John's, the New Brunswick plans, and Ontario Acute care, there is an additional requirement that

- family members must be prepared to help care for the patient.

Finally, eligibility for home care may be limited by the number of services a patient requires. In Ontario there is a clear definition of the levels of service available from the various programs. For instance, clients in Ontario Chronic Care must require over three health service visits per month, and less than 4 per day; they may receive up to 80 hours of homemaking in the initial month, but only 40 hours in following months, except in areas where the Integrated Homemaker Program has been introduced, where the limit will be 60 hours per month.

In St. John's, Prince Edward Island, Saskatchewan, Alberta and the Northwest Territories, acceptance of a client depends on the resources available. In New Brunswick, Manitoba, Alberta and British Columbia there is a clear statement that **acceptance depends on whether the cost of home care is less than the cost of institutional care.** This limiting provision would seem to be absolutely necessary if the costs of home care are to be kept within reasonable limits.

Generally speaking, the mentally retarded and handicapped are looked after by Social Services programs, rather than by home care.

Assessment and Placement

The key function of a home care program, as mentioned above, is coordination of services to the client. This occurs as a result of the assessment process, which follows the original referral to the program.

Most programs allow clients to apply directly and also allow referral, with the patient's consent, by other members of the community. Some, such as Ontario Home Care, require a physician's referral before assessment, but most are prepared to undertake preliminary assessment of what appear to be legitimate applications before consulting the patient's physician. Of course, in many cases the client is originally referred to the home care program by a physician. Most programs facilitate referrals from hospital

through liaison nurses who are either based in the hospital or visit it fequently to determine which patients can be discharged to home care. In these cases the liaison nurses perform the initial assessment.

Otherwise, assessors usually visit the applicants in their homes, to determine the applicants' health and social support needs and the suitability of the home as a setting for care. In most programs the decision to accept an applicant is made by the assessor herself (P.E.I., Ont, Man, Alta, N.W.T.) though difficult decisions will be discussed with the local unit supervisor. In some programs (N.B.,B.C.) the decision is made specifically by the unit supervisor and, in Saskatchewan, by the local assessment committee.

A growing trend has been to link assessment for home care to assessment for placement in homes for special care. In Manitoba, the home care assessors are specifically delegated the task of assessing for placement in homes for special care. In Saskatchewan and Alberta, the assessor who finds an applicant unsuitable for home care because of excessive care needs can recommend placement to the district committee specifically entrusted with assigning places in homes for special care.

If an applicant is found unsuitable for home care because too little or too much service is required, the assessor will usually direct the applicant to other sources of care. Ontario and St. John's Home Care specifically require their assessors to do so.

Following acceptance, the assessor usually becomes the case coordinator responsible for coordinating the services the client requires, based on a plan acceptable to the client. In a few large units, however, as in urban Saskatchewan, the assessor may be a different person from the case coordinator. Whatever the arrangement, reassessment of the client's needs occurs at regular intervals thereafter.

There would seem to be an obvious argument, from an economic point of view, for separating the assessment function from the delivery function, that is, for ensuring that the client's needs are not assessed by the same person who will subsequently be employed in providing care to the client. Nonetheless, as many programs entrust assessment to care providers as do not. Saskatchewan, Alberta, Prince Edward Island and the Extra Mural Hospital in New Brunswick all allow care providers to perform assessment. Ontario, Manitoba, British Columbia, and New Brunswick Public Health all separate the assessment from the delivery function. In St. John's Acute Care patients are assessed by care providers, while Long Term Care patients are assessed by the unit manager.

Personnel

Assessors may be health care professionals employed by the program or Public Health Nurses (in New Brunswick and British Columbia). Social Service workers are employed for assessment of cases that do not at first appear to have health care needs (as determined by initial telephone contact). In most programs, assessors tend to be health care professionals, because they can undertake both health and social support assessments, while social workers may have difficulty in determining an applicant's health care needs. Saskatchewan, however, has provision for lay people to become assessors, after they have received a special training in assessment. In some provinces, separate assessments by a health professional and a social service worker may be required to coordinate all aspects of care (New Brunswick Short Term Care and British Columbia Long Term Care).

Nurses providing in-home service are commonly direct employees of the home care program (Prince Edward Island, New Brunswick Extra Mural Hospital, Quebec, Manitoba, Saskatchewan, Alberta, British Columbia Home Nursing and some in the Northwest Territories). Some programs engage nursing services on a contract basis. This occurs in New Brunswick Short Term Care, Ontario, British Columbia Long Term Care, Northwest Territories and on an as-required basis in Manitoba.

The nurses on contract may be hired on an individual contract or from an agency. Home Care Program representatives in other provinces have suggested that using the VON agency can be difficult and in some provinces the VON is no longer involved in public Home Care Programs. The main problems noted with the VON include:

a) Cost of VON service. Until recently, VON required all services to be performed by Registered Nurses regardless of the complexity of the service, (i.e. routine tub-baths). Billing rates for the VON are based on per visit rather than per hour with no differential for the types of service required. (It should be noted the VON has recently begun to use some CNAs as Home Care Aides for services which do not require a Registered Nurse.)

b) Difficulty of supervision. For their private patients, VON are accustomed to undertaking the assessment of service requirements. Consequently VON may find it difficult to accept the level of service as determined by the home care program's assessor. Where the VON is itself responsible for assessment, home care unit managers tend to find that the level of service proposed is too high.

Programs differ in their willingness to employ Certified Nursing Assistants or their equivalents. Quebec and Ontario employ CNAs for nursing tasks, but Ontario is phasing them out. British Columbia is also phasing out CNAs for personal care, since homemakers are believed to be more cost effective. Meanwhile, Alberta programs find them preferable to homemakers for personal care, since the Nursing Assistants operate according to recognized standards. St. John's Home Care employs CNAs for personal care, and Manitoba employs Home Care Attendants, who are similar to CNAs, but given a special training at Red River Community College. The other provincial programs do not employ CNAs.

Homemakers, like nurses, may be either staff of the local home care unit or staff of a homemaking agency on contract to the home care unit. New Brunswick, most Ontario programs, British Columbia, St. John's Home Care and some Alberta programs prefer to contract with an agency; Quebec, Prince Edward Island, Saskatchewan and some Ontario municipal and Indian Band programs have homemakers on staff, while the Alberta program prefers to do so. Manitoba and the Northwest Territories hire homemakers from an agency or on an individual basis.

In fact, home care programs seem about equally divided regarding the merits of having care providers on staff as opposed to employing them on a contract basis. See Table 5 for the contractual status of Physiotherapists, occupational, speech and respiratory therapists, social workers, nutritionists and laboratory technicians.

Volunteer Services

While home care program staff or contract employees provide professional services to clients in the home, volunteers provide the essential services that keep up the spirits of clients shut in at home and help them lead as normal a life as possible.

All programs encourage close cooperation with local volunteer groups so that their services may be coordinated by home care case managers. In Prince Edward Island, a Community Support Worker is attached to each local home care office specifically to liaise with and promote local volunteer groups. The role of the local coordinators of Community-Based Services for Seniors in New Brunswick is similar. New Brunswick also has Volunteer Bureaus whose task is to recruit, direct and give recognition to volunteers for any volunteer agency, including agencies associated with home care programs.

TABLE 5: HOME CARE PROVIDERS ON STAFF AND ON CONTRACT/HIRED AS NEEDED, CANADA, 1986

	Alta		B.C.		Man.		N.B. (EMH)		N.B. (PH)		Nfld. (StJHC)		N.W.T.		Ont. (HC)		P.E.I.		P.Q.		Sask	
	S	C	S	C	S	C	S	C	S	C	S	C	S	C	S	C	S	C	S	C	S	C
Nurses	x[a]		x[b]		x	x[b]	x		x	x	x[c]	x[c]	x		x[d]		x		x		x	
Homemakers	x	x	x		x		x		x		x		x		x[d]		x		x		x	
Physiotherapists	x	x	x		x		x		x		x		x		x			x	x	x	x	x[d]
Occ. Therapists	x	x			x										x		x		x	x	x	x[d]
Speech Therapists					x										x				x	x		
Resp. Therapists					x		x								x				x	x		
Social Workers											x						x		x			
Nutritionists					x				x						x						x	x[d]
Lab. Technicians	x		x		x		x		x		x		x		x		x		x		x	

Abbreviations

S - on staff
C - on contract or hired as needed
EMH - Extra Mural Hospital
PH - Public Health
StJHC - St. John's Home Care
HC - Home Care Program

Notes

a) VON in 4 districts
b) On staff in Home Nursing Program; on contract for Long Term Care.
c) On staff for long term care; VON for acute care, but probably soon to be replaced by staff nurses.
d) Some on staff.

Essential Home Support Services are provided by a mixture of contracted agencies, hired helpers and volunteers in every province. A key service is meals on wheels which provides clients receiving care at home with a nutritious meal, supplementing or replacing meals prepared by homemakers. The meals are cooked by a local agency, such as Red Cross, a hospital, a home for special care or a local restaurant. Volunteers then collect the meals and deliver them to clients.

Everywhere programs prefer to obtain volunteers to undertake home repairs or to do house and yard maintenance or heavy housework but where necessary workers to perform these tasks may be hired on a fee-for-service basis.

Transportation is provided by volunteers everywhere, except in special instances, such as medical emergencies, when home care or medical staff may provide or fund transportation.

Everywhere volunteers maintain friendly contact by visiting or telephone calls and run errands, and do shopping or manage money for home care clients.

Most provinces rely upon the Red Cross Loan cupboard to provide short-term equipment loans. Patients requiring equipment for a long time are generally expected to purchase it themselves, with the aid of service clubs if need be. Ontario, Manitoba, Saskatchewan and Alberta have their own equipment loan plans which provide equipment for both short and long terms.

Users of Home Care

Differences in reporting practices and in the composition of core services between home care programs do not facilitate easy comparisons regarding the use of services in other jurisdictions.

Fortunately, Saskatchewan, whose population is similar in size to Nova Scotia's, and whose home care program provides a basic core of health and home support services, publishes a comprehensive statistical report. Figures from this statistical report were compared with available figures from other provinces in order to obtain general conclusions.

a) by age

Home care us used primarily by people aged 65 and over. In 1984-85, 85.9% of Saskatchewan home care clients were aged 65 and over.

This would seem to be a representative figure for a program that combines provision of health and home support services, either together or separately and which does not distinguish between acute and chronic care.

The percentages of seniors in other types of program vary. In British Columbia in 1983-84, seniors formed 85.5% of the client group for Long Term Care homemaker services, as is only natural, since Long Term Care is for Seniors and disabled over 19 only. In the same year, seniors formed 55.5% of the Home Nursing Care Program. If the clientele of the Home Nursing Care and Long Term Care programs are combined, seniors again form 87.5% of the total - comparable to Saskatchewan.

In Ontario Home Care, which is primarily a health services program, 61.3% of the caseload in 1982-83 was composed of seniors. Seniors formed 57.6% of the Acute Care caseload and 78.2% of the Chronic Care caseload.

It may be noted that in British Columbia, which has a separate Community Physiotherapy Program, seniors constituted 67.4% of the new patients in 1984-85.

b) by sex

Home care is a women's issue. Studies have shown that the great majority of home care clients are women. In Saskatchewan 67.7% of home care clients in 1984-85 were women. Shapiro, in her Home Care: A comprehensive overview (1970) reported similar percentages from Alberta (70%) in 1976, and Metropolitan Toronto in 1974-75.

c) by type of care

In her talk to the Nova Scotia Provincial Workshop on Home Care in April, 1986, Evelyn Shapiro indicated that 2/3 of home care users in Manitoba require homemaking services, 23-26% require nursing services and only 5% require physiotherapy or occupational therapy.

Shapiro (1979) observed that about 75% of the users of home care programs are the long-term or chronically ill. This applies, of course, only to programs which integrate acute and chronic care. For example, in British Columbia Home Nursing Care, which is separate from Long Term Care, only 6.3% of patients in 1983/84 had received care for more than 180 days.

In consequence of the high percentage of long term care clients in an integrated program, however, home support, particularly homemaking services, constitutes a high percentage of the actual care given.

In Saskatchewan's integrated program, for instance, 60.1% of all clients received homemaking services, which formed 56.8% of all service provided. (Saskatchewan's practice of 1 service hour or 1 meal = 1 service unit makes the volume of service easy to compute.) Although 45.8% of all clients received nursing this care constituted only 9.1% of the service provided. (See Table 6.)

New Brunswick Public Health estimated that Long Term Care was composed of about 70% homemaking and 30% nursing. Whereas Acute Care was about 10% homemaking and 90% nursing. The figures for Acute Care are borne out by Extra Mural Hospital, essentially an acute care program: 89.8% health visits, 10.2% homemaking visits in 1985-86.

Of the health care component of a home care program, nursing services are by far the most important, as is clearly shown by the Ontario bar graph (see Table 7, Social Services here refer to social work). Physiotherapy is a distant second. Similarly, in British Columbia, the Home Nursing Care Program admitted 42,417 new patients in 1984--85, while the Community Physiotherapy Program admitted only 2,338.

d) as a percentage of the population

The percentage of the population served by home care is very small. Evelyn Shapiro in her talk in Halifax estimated about 10% of seniors benefit from home care in Manitoba in any one year; and since seniors form about 10% of the population, this means that only about 1% (or at most 2%) of the population actually quality for home care.

Likewise, in Saskatchewan, in 1984-85 the statistical report shows that only 1.8% of the provincial population uses home care. (See Table 8.)

Financing Home Care

Home care in each jurisdiction is financed by grants from the Provincial or Territorial Government. In most jurisdictions, the home care program submits a budget proposal, through the Department responsible, to the Legislature, which votes the funds.

In Saskatchewan, where home care is provided by non-governmental home care corporations, the amount received by each local corporation is determined by a formula, viz:

$44,940 basic grant
+$10 per inhabitant of district
+$44.78 per senior citizen in district
+$30 per senior over 75 in district.

TABLE 6: VOLUME OF HOME CARE SERVICES AND NUMBER OF CLIENTS RECEIVING SERVICES, SASKATCHEWAN, 1984-85

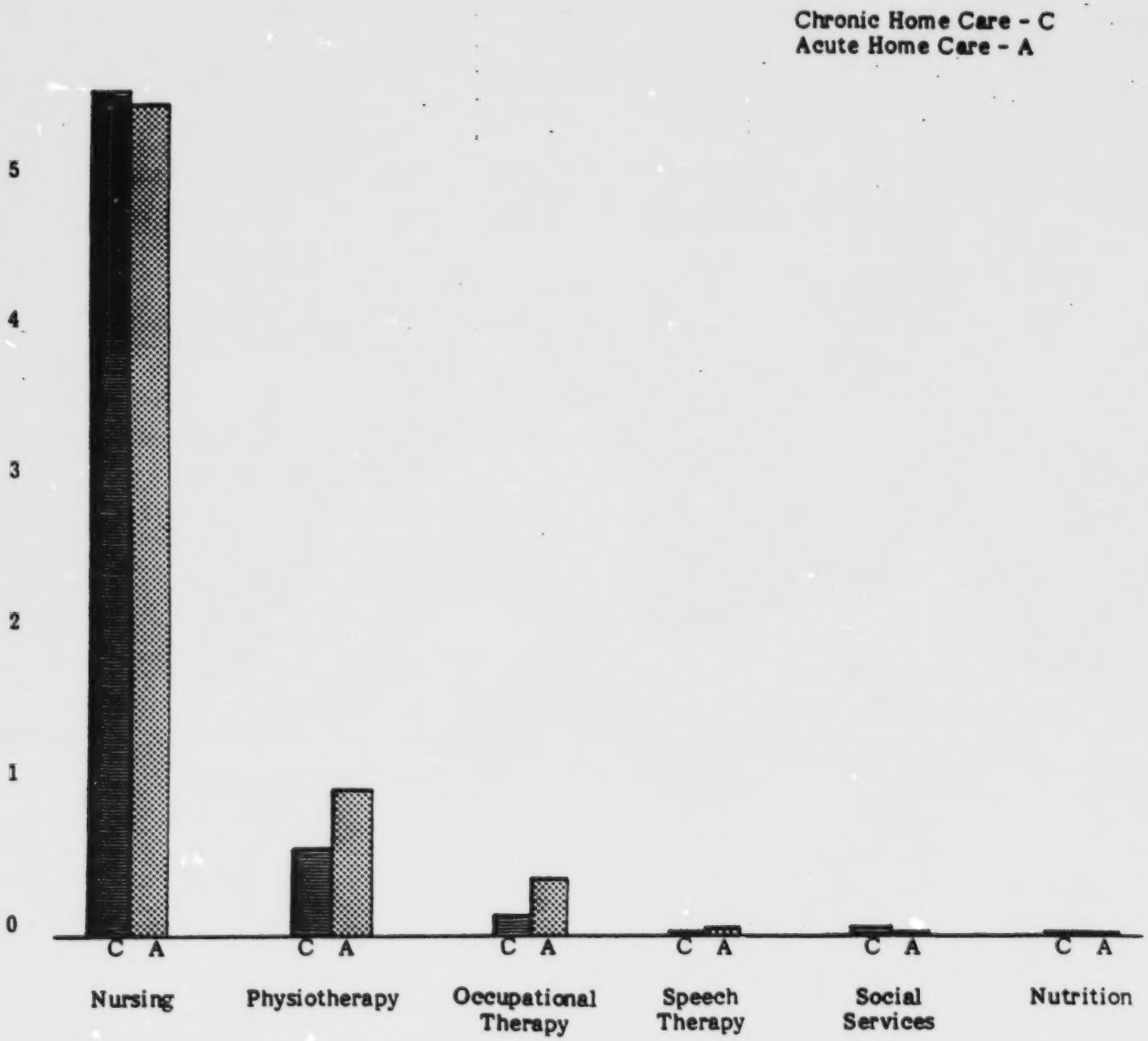
Type of Service	Volume of Service		Clients	Percent of all Clients
	Units[a]	Percent	Number	Percent
Nursing	110,960	9.1	8,110	45.8
Meals	387,339	31.7	4,490	25.3
Home Maintenance	29,163	2.4	4,276	24.1
Homemaking	693,883	56.8	10,646	60.1
All services	1,221,345	100.0	17,721[b]	-

a. Units of servide are defined as follows:

- one hour of homemaking, nursing or home maintenance service = 1 unit
- one meal = 1 unit

b. Some clients will have received more than one type of service. The all services total represents the discrete number of clients served by the program.

TABLE 7: PROFESSIONAL SERVICE VISITS PER CASE, ONTARIO 1982-1983



Note: These professional services relate only to the Health Service component of the Home Care Program.

TABLE 8: DISTRIBUTION OF HOME CARE CLIENTS AND ALL DISTRICT POPULATION BY AGE, SASKATCHEWAN, 1984-85

Age Group	Home care clients		All district population		Utilization Rate
	Number	Per cent	Number	Per cent	Per cent
0 - 19	119	0.7	300,127	31.1	0.0
20 - 39	544	3.1	316,437	32.8	0.2
40 - 59	1,015	5.8	180,107	18.7	0.6
60 - 64	783	4.5	44,561	4.6	1.8
65 - 69	1,560	8.9	39,468	4.1	4.0
70 - 74	2,713	15.5	32,655	3.4	8.3
75 - 79	3,493	19.9	23,481	2.4	14.9
80 - 84	3,452	19.7	14,644	1.5	23.6
85 - 89	2,411	13.8	7,569	0.8	31.9
90 +	1,429	8.2	4,481	0.5	31.9
Total	17,519	100.0	963,530	100.0	1.8

The corporation boards raise additional money through fund raising activities, community contributions and volunteer help. The government provides targeted grants to districts providing high need and respite care.

The home care expenditures in all jurisdictions are partly defrayed by Federal funding through EPF and CAP and fees charged to clients.

a) Fees

Throughout Canada there are no fees for health services, such as nursing and therapy. Some provinces provide drugs, dressings and equipment, as mentioned above, others do not.

In some jurisdictions, home support services are free of charge, in others there are nominal charges or a sliding fee scale.

Prince Edward Island, New Brunswick (Public Health) and British Columbia (Long Term Care) charge for homemaker services on a sliding fee scale dependent upon income and size of family. Ontario (Home Support) recommends user fees, but local units do not have to charge.

In Saskatchewan, all clients, regardless of income, are charged $2.50 or $3.00 for each of the first ten units of service received, a unit consisting of one meal or one hour of service. No client pays more than $250 a month.

In Alberta support services are free for the first two weeks. Then a client is charged $2 per hour and $2 or actual cost of meals, up to a maximum of $300 per month. The service is free to persons on GIS, Provincial Income Security and Widow's Pensions.

New Brunswick (Extra Mural), Quebec, Manitoba and Northwest Territories do not charge for home support services, except for meals.

There are no fees for home support services in St. John's Home Care. Ontario (Home Care) allows a certain number of hours of homemaker service per month free of charge. After that, clients must pay, provided the local unit has the resources to provide extra service.

Every program, whether the services are free of charge or not, sets a limit to the amount of service that can be provided. The most usual limit is the cost of institutional care. If the cost of providing service at home exceeds the cost of providing the service in an institution, the applicant is referred to institutional care. This is the practice in Alberta, British Columbia, Manitoba, New

Brunswick (Extra Mural and Community based Social Services) and Saskatchewan. Likewise, St. John's Home Care, Northwest Territories and Prince Edward Island limit services according to the home care resources available. Quebec sets priorities according to clients most in need.

Ontario limits according to service levels, as just mentioned, and New Brunswick (Public Health) by time (30 days) for Acute Care.

There are exceptions to these limits, for terminal care patients and patients waiting transfer to hospital, but all programs stated that a capping mechanism was essential, or costs would grow out of hand.

b) Cost Sharing and Recoveries

With respect to cost sharing and recoveries, all programs receive money for the health portion of home care through EPF.

Home support programs for needy persons are cost shared under CAP, except apparently for homemakers hired by Extra Mural Hospital in New Brunswick, since Extra Mural Hospital receives its funding from the Department of Health.

Income testing permits cost sharing for home support in Prince Edward Island, New Brunswick (Public Health and CBSS), Saskatchewan, and British Columbia.

In Alberta, there is automatic cost sharing for services provided to persons receiving GIS, Provincial Income Security and Widow's Pension upon provision of financial information to the Federal Government.

Quebec receives its CAP grants in the form of cash payments and tax transfers, similar to EPF.

Manitoba and Ontario have struck agreements with the Federal Government to avoid income testing, in Manitoba, CAP cost shares a percentage of the cost of services provided to persons over 65, that percentage being equal to the percentage of over 65s in the general provincial population who receive GIS (currently 58%). Ontario has struck a similar, slightly better deal, whereby CAP cost shares a percentage of the cost of services provided to persons over 65, that percentage being equal to the percentage of persons over 75 in the general provincial population who receive GIS.

Cost of Programs

Determining the total cost of home care programs in the rest of Canada is complicated by different reporting procedures and the inclusion of home care programs in larger budget items. Relation of costs to the actual number of clients served is even more complex, because some programs keep records of the number of clients served, some keep records of the numbers admitted and some only record the monthly caseload. (See Table 9.)

Of most interest to Nova Scotian policy makers are the figures from Saskatchewan and Manitoba, both provinces with a population a little bigger than Nova Scotia's but fairly comparable. In 1985-86 Saskatchewan spent $19,900,000 on about 18,000 clients (if Nova Scotia had the same utilization rate as Saskatchewan, there would be about 17,000 clients). Manitoba has 11,000 to 12,000 clients; in 1983-84 it spent $18,249,000 on home care, and in 1986-87 expects to spend $23,000,000. The Manitoba program provides a wider range of services than Saskatchewan's (see Table 4), and does not charge for home support. It is significant that Extra Mural Hospital estimated it would need a budget of about $22,000,000 if it were to assume provision of acute and long-term care in New Brunswick.

TABLE 9: INDICATIVE FIGURES OF COSTS AND CLIENTELE OF SELECTED HOME CARE PROGRAMS

Province and program	Year	Expenditures	Total Clients Served/Admitted	Monthly Caseload
British Columbia	1984-85			
- Homemaker services		$48,500,000	30,000	
- Home Nursing Care		$18,750,000	40,500	
- Community Physio-therapy		850,000	2,240	
- Adult Daycare		3,650,000	1,500	
Alberta				
- Home Care	1985-86	$28,000,000		N/A
	1984-85	23,000,000		9,500
	1983-84	18,000,000		7,047
Saskatchewan				
- Home Care	1985-86	$19,900,000		
	1984-85	18,600,000	17,721	
	1983-84	18,300,000		
Manitoba				
- Home Care	1984-85			11,537
	1983-84	18,249,500		10,918
	1982-83	16,225,100		
Ontario				
- Home Care	1982-83	$82,200,000	111,715	
	1981-82	67,300,000	102,684	
New Brunswick				
- Extra Mural Hospital	1986-87	$ 8,190,341		
	1985-86	5,754,481	5,896	
	1984-85	3,928,839		
- Public Health	1986-87	1,690,400		
	1985-86	1,718,850		
	1984-85	1,680,100		
	1981-82		4,544	
Newfoundland				
- St. John's Home Care	1984-85	$ 986,500		
	1983-84	977,067	2,066	
(Home Support for Seniors)	1984-85	164,000		
	1983-84	108,000	203	

IV. WHAT THE PEOPLE SAY

Interdepartmental Committee on Home Care, Senior Citizens' Secretariat and Senior Citizens' Commission Consultations, 1986

During the months of August, September and October, 1986, the Interdepartmental Committee of Deputy Ministers, the Senior Citizens' Secretariat and the Senior Citizens' Commission consulted individuals and community support organizations throughout the Province whose primary interest lay in ensuring the provision of an adequate home care program for Nova Scotians.

Public hearings were arranged in Sydney, Baddeck, Port Hawkesbury, Antigonish, New Glasgow, Amherst, Truro, Halifax, Dartmouth, Bridgewater, Kentville and Yarmouth.

Individuals and organizations expressing a wish to address the public hearings received the following list of questions to guide them in the preparation of their submissions.

1. What does "home care" mean to you?

2. Is home care essential in your area and, if so, for which groups of persons?

3. Why is home care essential for these groups of persons, i.e., what purpose(s) does home care serve?

4. What services must an appropriate, responsive and affordable home care program provide to the target groups identified above?

5. Should users of service(s) be expected to contribute to the cost of such service(s) and, if so, how should this contribution/fee be determined?

6. Who should be responsible at the local and the provincial levels for the following:
   - planning a home care program? (local level only)
   - developing a home care program?
   - coordinating a home care program?
   - receiving requests for home care service(s)?
   - assessing need, both service and financial?
   - financing the home care program?
   - providing home care service(s)?

7. Should there be a single entry point for home care at the local level and, if so, which organization(s) should carry this responsibility/mandate - the Province through the Department of Health or Social

Services; the municipalities through their Social Service Departments; or the private sector, e.g., Senior Citizens' Centres, Red Cross, etc.

8. If you feel a single entry point for home care is not necessary in your area, how would you envision a home care program being co-ordinated.

9. Which home care service(s) does your agency/organization now provide?

10. What new and/or additional service(s) are required to ensure an appropriate, responsive and affordable system of home care? What do you estimate these additional and/or new services would cost in the first full year of operation under your present eligibility guidelines? How should these additional costs be allocated?

11. What role do you see for volunteers and volunteer agencies/organizations in the provision of an appropriate, responsive and affordable system of home care?

In addition to addressing the nature and extent of need, the individuals and organizations presenting were asked to comment on

- what now exists in their communities;
- how well it is working and why;
- what new and/or additional services are required and for whom;
- the role which should be played by government, the private/voluntary sector, and the users of service in the planning, development, delivery and financing of a coordinated, comprehensive home care program.

Twenty-four provincial organizations, including the Nova Scotia Medical Society, the Victorian Order of Nurses, the Registered Nurses Association, Comcare, the Federation of Senior Citizens, Nova Scotians for Home Care and the Canadian Red Cross presented their views and recommendations on the development and implementation of a home care program.

In all, more than 300 local and provincial organizations attended these hearings and 70 submitted written briefs. Although many of the presentations came from organizations whose primary client group was seniors, a significant number of representations were made on behalf of the disabled and families at risk.

A detailed listing of the individuals and organizations involved in the consultations is contained in Appendix 6.

In light of the Government's directive to the Deputy Ministers of Health, Housing and Social Services in the February 27, 1986 Throne Speech - "to coordinate a comprehensive home care program for Nova Scotians" - the community consultations tended to place primary emphasis on

- **who** requires home care
- **what** home care services should be provided, and
- **how** to implement a coordinated, comprehensive home care program for Nova Scotians which would be appropriate, responsive and affordable.

While each group attending the community consultations tended to address the questions raised by the consultation committee from the vantage point of their own particular agency, area and client group, there was a fair degree of consensus on the "who", "what", and "how" of a coordinated, comprehensive home care program - at least for the initial stages of program implementation.

1. Need for Home Care

The hearings recommended that an accessible province-wide coordinated home care program is needed for all Nova Scotians who require it - particularly the elderly, the physically and mentally disabled, the mentally ill and families at risk.

Over and over again the consultation committee was told that there are many programs/services in place but that these programs/services are not coordinated. Consequently the public has a limited knowledge of the programs/services available and how to gain access to these services.

The Medical Society of Nova Scotia in its brief stated that "Many services for helping sick or disabled persons to recover or be maintained at home already exist" and "a coordinated home care program should be the primary health care priority in Nova Scotia for 1986."

2. Essential Home Care Services

The hearings recommended that the minimum components of the first phase of the home care program must include a range of coordinated health and social services including homemaking, home nursing, physiotherapy services, and attendant care (for the disabled) delivered to individuals and/or families in their own homes and communities on a short and long term basis. For limited periods of time such services may need to be available to certain clients 24 hours a day, 7 days a week.

The Registered Nurses Association of Nova Scotia in its publication "A Model for Home Care in Nova Scotia" divided home care services into the following categories:

> professional - including nursing, medicine, physiotherapy, occupational therapy, nutrition counselling, speech therapy and social work;
> support - including day care for seniors, respite care, diagnostic lab tests and x-rays, prescription medications, surgical dressings and other medical supplies, hospitals/sick room equipment, teaching, information and referral services and homemaker services;
> volunteers - including meals-on-wheels, wheels-to-meals, friendly visiting, library, transport of patients to medical appointments, delivery of medical equipment, home companions (possibly through church groups), home handyman services, and snow clearance assistance.

In addition to the general services outlined above the local consultations identified a number of service needs specific to particular groups or to particular areas or regions.

The Disabled Consumers Society of Colchester County, in addressing the need for attendant care, pointed out that "such care can make life safe, less lonely, more comfortable, allow for added independence and generally make life worth living once again." The Children's Aid Society of Halifax proposed that the new home care program include provisions for extending the teaching homemaker program, the specialized foster home program and the subsidized adoption program. The Canadian National Institute for the Blind saw the inclusion of their Vision Rehabilitation Services, Orientation and Mobility, Rehabilitation Teaching, Volunteer Services and Adaptive Aids and Devices in the new home care program.

The Baddeck consultation highlighted the need for a snowshovelling and transportation service while the Port Hawkesbury and Bridgewater consultations addressed the need for an adequate transportation service. In some areas the consultations pointed out how difficult it is to recruit volunteers to assist with the home care programs while in other areas the individuals and organizations presenting spoke highly of their volunteer effort and felt that with proper training, support and recognition they could sustain and add to this volunteer effort.

3. Benefits of Home Care

In addition to improving the quality of life of the clients through fostering maximum personal independence, self-reliance and freedom of choice, most groups attending

the hearings were of the opinion that an adequate home care program would serve to delay or prevent admissions to hospitals and other institutions and would facilitate earlier discharge from hospitals.

According to Family and Children's Services of Cumberland County, home care serves the following purposes:

- To provide support and services to persons in their own homes.
- To eliminate inappropriate admissions to institutions.
- To support and relieve strain on care givers.
- To reduce the costs of maintaining persons in alternate placements.

Speaking to the merits of home care, the Nova Scotia Hospital brief noted:

> It has been demonstrated that home care enables people to spend less time in hospital either by avoiding admission altogether or by decreasing length of stay.
>
> Recovery may be enhanced and sustained if individuals are treated in their home environment. Some favourable results cited in current literature include shorter convalescence, fewer readmissions, lower death rates and lower mortality rates.
>
> Treatment in one's home environment may decrease dependence on the health and social service systems and promote family involvement in care. In Nestman's study, (1981) 83% of family members felt that by receiving home care, the patient was able to stay at home, be more independent and was better served than if receiving hospital services.
>
> Quality of life and consumer satisfaction may be enhanced. Echeverri and colleagues (1972) for example, reported that 95% of home care patients were pleased with their care in contrast to 80% of hospital patients.
>
> Treatment at home also enables a person to spend most of his/her time with relatively healthy people as opposed to ill people. This is particularly beneficial for the mentally ill person who may have difficulty in interpersonal relationships.

4. Top Priority: Coordination

Invariably the groups attending the community consultations felt that many of the required home care services existed in their communities but that the extent of such services varies from community to community and there is little or no coordination of existing services. **Most, if not all, groups presenting recommended that the coordination of existing home care services be addressed immediately as the top priority.** Such coordination, the groups felt, could only be realized by placing the control of local resources, including budget and personnel, in the hands of the local coordinator or manager.

The South Shore Regional Hospital, in explaining their model for home care, urged that

> the emphasis be first upon coordination in order to make the best use of those resources now present in the community. A second emphasis is upon consultation and planning to identify new services that may be needed if reductions in hospital and nursing home use are to be achieved.

In the same vein, the Seniors Home Care Action Committee noted

> within Nova Scotia, there are a variety of services providing home support and health care enabling seniors and others to remain in their own homes instead of entering an institution. The coordination of these services would make them more available, more effective and would point up the gaps.

5. User Fees

The question on user fees elicited much lively discussion and debate. **The majority of groups presenting favoured a sliding fee scale based on ability to pay for the social service components of home care, but did not support a user fee for the health components of home care.** Generally speaking, the response to the user fee question seemed to endorse the status quo with respect to user fees for health and social services. Most of those presenting felt a charge for any component of health care was tantamount to turning back the clock. For the most part, professionals tended to be more strongly opposed to user fees than were users or potential users. Many seniors speaking on behalf of community support groups seemed to feel a minimum user fee based on a person's ability to pay would enable the user to retain his/her dignity.

The Antigonish Home Care Committee took the position that "essential services", defined to include those that prevent institutionalization should be free while "optional services" defined as those that enhance the quality of life, be subject to a fee based on ability of the user to pay.

The Community Care Division, Department of Social Services, City of Dartmouth, recognized the need to adopt the present fee structure to expedite a coordinated home care program. Nevertheless, they urged that "continuing effort be directed to developing a no user fee health and social services package pertaining to both institutional /and Home Care Programs".

Nova Scotians for Home Care contended that "a fee structure may deter the use of services in a home care program;" "that the administrative costs involved with collecting fees far outweighed any cost benefit according to the Manitoba study;" and, further, that "the use of admission criteria to the program could provide alternate control mechanisms that should be considered."

Northwood Care Inc. in their brief noted that the Canadian literature would suggest that "the nursing service component of home care is free only. The other support services on the whole appear to require some payment of service that needs to be considered in terms of the dignity of the client and to avoid abuse of the service."

All groups recommending a fee structure would, however, support the position taken in the St. Mary's Homemakers Service Association brief that "no one should be refused the service on the basis of being unable to pay."

6. Local and Provincial Organization

The questions relating to responsibility for home care at the provincial and local levels received a good deal of attention at the public hearings. **At the provincial level the preponderance of opinion seemed to favour the establishment of distinct, highly visible organizational entity whose sole mandate would be the planning, development and implementation of a coordinated, comprehensive home care program for Nova Scotians.** Other less frequently suggested possibilities included placing the home care program under the Departments of Health and/or Social Services. The Royal Canadian Legion, Nova Scotia command, went so far as to recommend the creation of a new Ministry for home care because of the size and importance of the task.

The proposed new organizational entity - sometimes referred to as a Commission - would be headed by an Executive Director who, along with an Advisory Committee of professionals from the home care field, would be responsible

to a single minister for the establishment and monitoring of policies, guidelines, standards, and budgets for a coordinated, comprehensive home care program throughout the Province.

The Gerontology Association of Nova Scotia saw such a Commission directed by a "multi-disciplinary Provincial Advisory Board composed of individuals representing facets of home care throughout Nova Scotia." The Commission would be responsible provincially for "program development and implementation, setting and monitoring of standards and the ongoing evaluation of the home care program".

Aside from the payment of professionals serving in an advisory capacity and the costs associated with the appointment of an Executive Director, the consultations did not expect that there would be any major administrative expense in establishing the Commission. Indeed, it was repeatedly emphasized that the Commission should be a small body with a minimum requirement for staff and the major personnel resources should be placed in the regions for purposes of coordination and service delivery.

At the local or regional level the major problem appeared to be one of coordination of those home care services now in place, although a number of groups highlighted major service gaps and/or deficiencies and the need for maximum flexibility at the local level in responding to service requirements. **The single request overriding all others at the local level was for the appointment of a Regional Coordinator and Regional Boards or Councils with a mandate and the resources required to coordinate existing home care services and to identify, in order of priority, additional service requirements. Most groups, with the exception of some hospitals and the cities of Halifax and Dartmouth, saw this coordination function as a Provincial responsibility.**

Speaking to the role and function of the Coordinator and Board or Council, the Nova Scotia Gerontology Association in its brief said

> At the local or regional level the coordinator and the advisory board or council would be responsible for the assessment of client needs, the development and implementation of care plans using local services, the review and revision of such care plans as clients needs dictate, budget control, the establishment and maintenance of information reporting systems and procedures and the ongoing monitoring of service needs.

It was the opinion of the Seniors Home Care Action Committee that

> At the provincial level a broad-based, multi-disciplinary advisory committee is essential to help establish the needed structure and develop meaningful standards. A key element in the community support system will be centres and advisory committees in seven or eight designated regions. The regional centres will be responsible for developing and implementing the most appropriate range and mix of community support services. At the regional and local level, it is also crucial that an inter-disciplinary approach be taken to all aspects of the operation of a community support system.

7. Single Entry Point: One Stop Shopping

A single entry point at the local level was perceived as essential. The majority of groups presenting felt there should be a single entry point in each region where comprehensive assessments are done by qualified staff to determine the most appropriate forms of support and to ensure a continuum of care is provided.

8. Separation of Assessment and Delivery Functions

All groups supported the separation of coordination and needs assessment functions from the service delivery function. Over and over again the consultation committee was advised of the need to establish a separate assessment team/unit under the coordinator whose role and function would be

- to assess the home care services required by an individual or family;
- to make the necessary referrals to appropriate service agencies who would be paid on a fee for service basis; and,
- to follow up on a timely basis.

Speaking to this issue, the Antigonish Home Care Committee said, "the assessment staff should be separate from the service providers and acceptance into the home care program must be made at the local level". Such an approach, the groups felt, would go a long way toward ensuring the most effective and efficient use of scarce resources.

9. **See Chapter II, on services currently provided.**

10. Financing

Practically all groups presenting were of the opinion that the bulk of the financing for a coordinated, comprehensive home care program should continue to come from the provincial and federal levels of government; that individuals who are able should be expected to make some contribution toward the non-health care components of home care; and, that municipalities continue their support of needy persons requiring home care.

The position of the Arthritis Society reflects the majority opinion:

> We would recommend that the medical components of a home care program be designated as an insured service and paid for by tax revenue. For non-medical services, we propose a sliding scale of user fees based on the individuals ability to pay.

11. Role of Family and Volunteers

All individuals and groups spoke at length to the essential role of the family, volunteers and service clubs in any home care program and the need to ensure the home care program is designed in a manner which encourages, fosters and supports family and volunteer community efforts. This will require a support structure of skilled personnel whose task is to enlist, encourage and develop voluntary and family services.

The Arthritis Society saw

> agency volunteers being involved in many supportive roles which can complement the professional services provided through a comprehensive home care program. Activities such as friendly visiting programs, making daily telephone contact, taking clients for drives and to church and those other human contact activities which will contribute to the psychological well being of the individual.

A good volunteer effort, the groups felt, could only be realized in the context of proper selection procedures, preparation, supervision, support and recognition. As well, some provision would need to be made for out-of-pocket expenses by volunteers.

The Nova Scotia Hospital in its brief stated

We support a very active role for volunteers, friends, family members and self-help groups in the planning and maintenance of a Home Care program. We believe one of the most significant and long-lasting benefits of provincial Home Care systems is the fact that they allow and encourage much greater participation from these groups than do institutional systems. If volunteers, consumer groups, individuals and their families are actively involved in the planning and development of a provincial system, their contribution will grow and will likely lead to considerable savings to the overall health and social service system.

We recognize, however, that the participation of the aforementioned groups must be supported, supervised and monitored in order to protect both clients and volunteers. This will require initial training and orientation programs and effective ongoing supervisory systems.

Over and over again the consultation committee was told that the home care program must maximize the contribution of family members and the volunteer sector including service clubs if it is to be successful and that this will only occur if the home care program is designed with this objective clearly in mind.

12. Regional Coordination

This document has made repeated reference to the need for local coordination of existing and new home care services and the words local and region have been used interchangeably. What is meant by the words "local" and "regional"? The consultations with few exceptions viewed the "region" as a unit in which coordination of services may be managed effectively because of size, geographical and cultural characteristics.

13. Implementation

As stated earlier, virtually all groups were of the opinion that many of the required home care services already exist and that our first task must be to ensure these home care services are properly coordinated.

At the same time many groups showed appreciation of and support for proceeding gradually in the development of new and/or additional home care services. Such development, it was generally agreed, should be proceeded by a careful assessment of the local situation - a priority assignment of the local coordinator, once appointed.

Observations

A number of observations can be made on the community consultations.

First, an accessible, province-wide, coordinated home care program is needed for all Nova Scotians who require it - particularly the elderly, the physically and mentally disabled, the mentally ill and families at risk.

Second, the justification for a home care program lies as much in improving the quality of life of the client, through fostering maximum personal independence, as in delaying or preventing admission to, or facilitating early discharge from, hospitals and/or homes for special care.

Third, all groups saw the need to separate the assessment and service delivery functions. Over and over again the consultation committee was encouraged to establish an assessment unit under the local regional coordinator who would be responsible for assessing the applicants' needs, determining the home care services required by the applicants, making the necessary referrals to service agencies and following up on a timely basis.

Fourth, a home care program should include assessment, homemaking, home nursing and physiotherapy services on a short and long term basis and attendant care (for the disabled).

Fifth, many of the required home care services now exist throughout the province but coordination is lacking.

Sixth, the coordination of existing private and public home care services at the provincial and local levels should be addressed as the top priority.

Seventh, at the provincial level such coordination would best be effected by the establishment of a distinct, highly visible organizational entity.

Eighth, a similar structure would be provided at the local level. The system at the local level would be structured to ensure a single entry point for people requiring service and maximum flexibility in responding to local needs.

Ninth, new and/or additional home care services should be implemented gradually based on a detailed assessment of the needs and resources at the local/regional level.

Tenth, funding was perceived to be first and foremost a provincial/federal responsibility although a number of groups felt municipalities should continue their support of home care services for needy persons and the individuals who are able should be expected to make some contribution toward the non-health care component of home care.

Eleventh, all individuals and groups spoke at length to the essential role of family and volunteers and the need to design a coordinated home care program which encourages, fosters and supports family and volunteer community effort. The achievement of this goal will require a support structure of skilled personnel whose task is to enlist, encourage and develop voluntary and family effort in the provision of a home care program.

PART II

A COORDINATED HOME CARE PROGRAM FOR NOVA SCOTIA

V. PRELIMINARY CONSIDERATIONS

The Interdepartmental Committee recommends that a coordinated home care program should be introduced in Nova Scotia. Nonetheless, before this report makes any recommendations concerning the specific form of coordinated home care program this Province should adopt, it is necessary to have a clear idea of what a coordinated home care program is intended to do. This chapter will examine the purpose and objectives of a coordinated home care program, the organizational means of attaining the objectives, the nature and expected size of the client group, the services to be provided and the organization of, and general criteria for, assessment for service.

The coordination of assessment and service is considered in greater detail in the following chapter (VI), which examines three different options for the structure and organization of a coordinated home care program. Chapter VII considers the costs of administration and service of the various options. Chapter VIII embodies the Interdepartmental Committee's conclusions and specific recommendations concerning the most suitable home care program for Nova Scotia.

In its deliberations concerning the most suitable home care program for Nova Scotia, the Interdepartmental Committee was guided by the following considerations:

- the program should make maximum use of existing services, administrative structures and financial arrangements
- the organizational structure must assure coordination at three levels - provincial, local and for the individual client
- the coordinated home care program should be highly visible and easily accessible to the general public
- the program must be able to grow and expand, starting by coordinating existing services, developing key services and adding other services as the need is identified
- the program should make maximum use of volunteer services and should encourage the further development of volunteer services.

The program should be phased in gradually. All groups and organizations consulted recognized that at least one year should be spent in developing an agency to coordinate existing programs. The Registered Nurses Association,according to the model of home care it presented to the Committee, would not expect the first client to be admitted until eighteen months after authorization was given to implement the program. This responsible public attitude reflects the belief that the program

should be well thought out and coordinated so that Nova Scotians do not suffer from a hastily conceived and disjointed program.

The hearings also indicated that the public is prepared to pay for homemaker and certain social services. The Committee has accordingly made its recommendations assuming that some of the costs of these services should be defrayed by persons receiving the service.

Purpose of a Coordinated Home Care Program

Coordinated home care (called hereafter just home care or the home care program) may be defined as

> the coordinated delivery of a range of health, housing and social services to meet the needs of the persons who require assistance or support in order to remain at home or whose functioning without coordinated home care is likely to deteriorate, making it impossible for the person to stay at home in the community.

('Home' in the definition means the person's normal place of residence.) This definition indicates the importance of both social services and health services. Homemaking, as the experience of other provices shows, is the service most in demand in home care programs that do not have medical criteria for admission. Department of Housing programs enable the elderly and disabled to remain in their own homes. Consequently, the coordinated home care program must work closely with the Department of Housing to ensure that program clients have homes that are appropriate for the delivery of care.

The Interdepartmental Committee on Home Care believes that the principal purposes of a home care program are:

1) to provide coordinated multidisciplinary care for an individual in his or her familiar home setting;
2) to maintain the integrity of the family unit and to encourage family involvement in the care of the individual;
3) to help persons in the program to achieve the greatest degree of independence possible. This may mean curing a health problem so that, with the help of home care staff, the person may continue to live in his or her own home. It may involve teaching persons in the program a healthier lifestyle or how to cope with illness or disability in managing their daily lives;
4) to prevent or delay admission or readmission of people to institutional beds. Institutional beds include beds both in hospitals and in homes for special care.
5) to facilitate early discharge from hospital, thus reducing the length of stay in acute care or other institutional beds.

The primary purpose, and justification, of a home care program is that it is perceived to improve the quality of life of the clients or patients in the program.

The argument is sometimes made that a home care program will reduce hospital expenditures on care by permitting the early discharge of patients to the home care program. There are some savings in treating patients at home, such as the reduced overheads in providing oxygen or renal dialysis to patients at home, rather than in hospital. It is, however, equally likely that per diem hospital costs may rise with the introduction of a home care program, because people requiring less expensive convalescent care in hospital can be discharged to the program after fewer days in hospital, and the beds these patients vacate can then be filled by patients requiring higher cost acute care. As in the hospitals, removing persons requiring the lower cost forms of care from nursing homes may simply free the beds for persons requiring more intensive care, particularly as the percentage of elderly in our population increases.

Nor is it clear that a home care program will reduce the need for more hospital and nursing home beds. A recent study by the Rand Corporation indicates that between 1973 and 1983 there was no appreciable difference in the percentage annual increase in the number of nursing home beds in Manitoba, where there was an extensive home care program, and Ontario, where the program was not so well-developed. It may be that the home care program will delay the need to build new institutions, but there is no definite proof of this.

In general, at the beginning, the costs of the home care program will be additional to those in the health and social service fields. Eventually, home care is unlikely to diminish institutional costs, though it may slow the demand for institutional beds, since persons requiring less intensive care can be cared for at home.

People seem to convalesce better in familiar surroundings, and elderly people are usually strongly attached to their homes and wish to stay in them, with help if need be, as long as possible. These are the primary and, the Interdepartmental Committee believes, more than adequate justifications for a home care program in Nova Scotia.

Means of Attaining the Objectives of the Home Care Program

Having established the general purpose of a home care program, it is necessary to delineate the general means by which the program attains its objectives. The Interdepartmental Committee, after considering the Manitoba Home Care Policy Guidelines and the RNANS Model, recommends that a program should

1) provide an assessment which determines whether a person's care needs can be met appropriately at home

2) develop and provide services in the home to those persons for whom this is the appropriate form of care
3) ensure that services provided to persons at home are coordinated so that the persons receive the full range of care and the appropriate levels of care that they need
4) relieve excess stress on family members and, in doing so, prevent the breakdown of a desirable living arrangement and/or the health of the person or persons providing care
5) increase self care skills which promote recovery from or prevent or delay progress of disease
6) facilitate placement into care facilities for those for whom home care is not appropriate
7) continuously evaluate the impact of the home care program on the target population and on other health care delivery systems.

More specifically, the home care program requires a distinct structure to enable it to attain its objectives. As seen in chapter 3, most home care programs have an administrative structure that permits coordination at three different levels

1) a central coordinating agency, that coordinates and directs a program across the province or territory
2) local coordination, that coordinates services in a defined region
3) case managers, who usually assess applicants to a program and coordinate the delivery of services to them on an individual basis.

The duties of the central coordinating agency include

1) development of policy guidelines, levels of service and procedures for the home care program, thus ensuring standardized service across the province or territory
2) administrative coordination of the assessment, placement and delivery services
3) coordination of the program with related providers of health care and social services, such as hospitals, homes for special care and municipal social assistance departments
4) budgeting for and funding, in whole or in part, the home care system
5) establishment of reporting procedures and maintenance ofinformation and data files whereby the success of the program may be evaluated.

The duties of local coordination are:

1) local development and coordination of resources required for the delivery of home care services
2) coordination of assessment for care and determination of applicants' eligibility
3) securing signed consent forms and contracts for services
4) coordination of care planning and of the delivery of services

5) review and revision of client care plans and of services provided as clients' care needs change
6) discharge assessment and termination of service
7) budgeting and exercise of local responsibility and control based on allocations made for home care by the central office and other providers of revenue
8) maintenance of required program procedures and information reporting systems.

The duties of the assessor/case manager are:

1) assessment of each person referred, which will usually include consultation with the person making the referral and the applicants' family or friends and, for health care, the person's physician
2) identification of the applicants' needs
3) securing signed consent forms and contracts for services
4) establishment of the applicants' eligibility for the home care program
5) if the applicant is accepted, development of a care plan that coordinates the services of local care providers. This plan should be developed in consultation with the client, as well as with relevant other persons, such as the client's physician and family. This plan must be agreed to by the client
6) completion of assessment and reporting forms
7) maintenance of a case record for all clients.

The Home Care Program's Client Group

The home care program should coordinate and supervise services to all eligible persons, regardless of whether they require only one kind of service (homemaking or nursing or volunteers) or a combination of services. Other approaches, which use selection criteria, such as age limits and need for medical services, to limit size of the client group could cause as many problems as they solve.

Limitation of coordinated home care services to persons 65 years of age or over would mean that people below that age, newly discharged from hospital, would not benefit from the full range of coordinated services; the Community Health Nurses and homemakers who would be cooperating to provide coordinated services to the elderly would be expected to coordinate services for, say, the young independently of each other. In practice, it is easy to see what would happen: the links between the care providers established by the formal home care program for the elderly would be used to provide coordinated care for other persons, and there would thus be little difference between the two systems, except perhaps in fee schedules.

Limitation of the client group to persons who require one specified health care service and ancillary support services may be called the medical model of home care. It currently functions in Newfoundland, New Brunswick and Ontario, though the last province is now moving away from it. The medical model was almost universally condemned by participants in the public hearings, on the grounds that it stressed treatment of illness, rather than prevention of illness and promotion of health. The opponents of the medical model argue, furthermore, that home care is not just an alternative to institutionalization in a hospital but it is an alternative to institutionalization in a home for special care, as well. Homemaking, for instance, may enable an elderly woman to continue living in her own home, rather than applying for admission to a home for special care. It may also prevent her from doing herself an injury while trying to do household chores that are beyond her ability, and thus prevent her from becoming a patient needing health care. Taking these two considerations into account - that home care is intended to prevent both illness and institutionalization - the Committee recommends against the medical model of home care.

a) Size of Client Group

Given that the client group of the home care program is assumed to be all Nova Scotians in need of home care, it becomes necessary to estimate the size of this group and its characteristics.

As mentioned in chapter 3, the size of the client group in other provinces is between 1% and 2% of the population. This figure represents the client group after a home care program has been in operation for some years, and varies according to the public awareness of the program and the number of services provided. The size is also proportionate to the percentage of elderly in the general population, for the elderly constitute about 60% or more of a home care program's client group.

Since any program in Nova Scotia would be in its early stages, the number of clients expected would probably range from the number now being served by homemakers and nurses delivering in-home services and a number representing 2% of the population. The total number of clients actually served at home by nurses cannot be determined from the statistics available, which record the total number of visits, rather than the total number of clients visited. A recent survey by the Senior citizens Secretariat of homemaker agencies, however, suggests that the 37 agencies currently serve about 3,000 clients, of whom 2,400 are aged 65 or over.

The upper figure, of 2% of the population, represents 17,300 persons out of Nova Scotia's estimated population of 865,442 in 1986. As mentioned before, Evelyn Shapiro estimates that 10% of all elderly persons in Manitoba are likely to require home care.

Applying this figure to the estimated Nova Scotian population of 100,400 people 65 and over in 1986, the calculation indicates that some 10,000 elderly could conceivably require home care.

Table 10 shows the results of these calculations in section 1. Section 2 indicates the number of seniors identified by Statistics Canada's General Social Survey of 1985 as unable or needing help to perform certain daily tasks. These are probably the upper limits for the numbers of people requiring assistance, since many of the people in section 2 will already be helped by their relatives and friends. These figures include persons currently in institutions but give some idea of the upper limit of the client group of a home care program providing the services mentioned. It should be observed that heavy housework and yardwork are not often provided by homemaking agencies in Nova Scotia at present; these tasks tend to be performed by friends and relatives of people needing help. Section 3 of the Table will be discussed in the following section, on services, but it should be observed that homemaking, followed by nursing, is the service chiefly in demand.

The number of persons requiring home care in Nova Scotia may be expected to increase in coming years as the population ages. In 1986, people 65 and over formed 11.6% of the population, while persons 75 and over formed 4.6%. Between now and the end of the century, the number of seniors will increase by about 30,000, and most of this increase will be due to an increase in the number of seniors over age 75. (See Table 11) In 2006, Statistics Canada projections suggest that there will be 134,900 senior citizens aged 65 and over in a Nova Scotian population of 911,300. Thus, senior citizens will form 14.8% of the population, and persons 75 and over will form almost half (48.1%) of the total number of senior citizens, and 7.1% of the population of the Province.

Thus, by the year 2006, if 10% of all seniors still require home care, there could be a client group of at least 13,500 seniors. Given the increased number of persons over 75, there could be an increased demand for the nursing component of home care, and more demand for homemaking services.

Services to be Provided

As noted in chapter 3, home care programs in Canadian jurisdictions provide a variety of services. Chapter 4 noted that the sense of the public meetings in Nova Scotia was that the home care program should provide coordination of existing services as the initial step, and that the key services to be coordinated were nursing, homemaking, physiotherapy and attendant care. There was also a consensus that agencies using volunteers would play a big part in making the program successful, by providing such services as friendly visiting and the delivery of meals on wheels.

TABLE 10: SIZE OF CLIENT GROUP REQUIRING HOME CARE

1. Size of client group as a percentage of population

a)	Total population (1986)	865,442
	2% = client group in comparable provinces	17,300
b)	Senior Citizens	100,400
	10% = % of seniors estimated to need home care	10,000

2. By needs identified in General Social Survey (1985)

Prorating figures from Canadian totals, number of seniors unable to do, or needing help in doing:

Yardwork	47,000
Heavy housework	32,000
Meal preparation	11,000
Grocery shopping	20,000
Managing money	6,000
Personal care	4,000

3. By applying utilization rates from other Provinces.

a)	Home care for all		17,300
	Number requiring homemaking	60%	10,400
	nursing	46%	8,000
	meals	25%	4,300
	home maintenance	24%	4,200
	maintenance occupational therapy	2%	300
b)	Home care for seniors		10,000
	Number requiring homemaking	60%	6,000
	nursing	46%	4,600
	meals	25%	2,500
	home maintenance	24%	2,400
	physiotherapy	7%	700
	occupational therapy	2%	200

(Percentages based on Saskatchewan and Ontario figures.)

TABLE 11: POPULATION PROJECTIONS, NOVA SCOTIA, 1986 - 2006

	Population	Population over 65	% of Population	Population over 75	Percentage of Population over 65
1986	865,442	100,400	11.6%	39,800	39.6%
1991	894,700	115,200	12.9%	49,000	42.5%
1996	903,900	123,200	13.6%	56,500	45.9%
2001	910,000	129,400	14.2%	62,400	48.2%
2006	911,300	134,900	14.8%	64,900	48.1%

Source: Statistics Canada catalogue 91-520 and 1986 Census of Canada.

The Interdepartmental Committee believes that the first priority is to establish a mechanism that will coordinate existing services. Options for the best coordinating structure will be discussed later in this report. This structure will ensure that the new coordinated home care program will provide Nova Scotians with the same level of necessary services as they have now.

The Committee believes, however, that the program should not over extend itself by attempting to coordinate too many services in its early years. The program should concentrate initially on coordinating the provision of services which the experience of other provinces shows to be the most necessary for the largest number of clients.

Homemaking and nursing are clearly the key services that meet the needs of the largest percentage of the client group: 60% of clients require homemaking, 46% require nursing (see Table 10, section 3). (It should be noted, however, that in terms of volume of service, calculated in hourly units, homemaking represents 56.8% while nursing represents only 9.1%.) The percentage of clients requiring nursing may not be so high; these percentages are based on the Saskatchewan figures, but Evelyn Shapiro states that only 26% of home care clients in Manitoba require home nursing. In making its calculations, however, the Interdepartmental Committee has preferred to err on the high side.

The relatively low utilization rates of physiotherapy and occupational therapy should be noted, even in Ontario, where both are critera health care services. (In Ontario, a person is not eligible for that Province's medical model of coordinated home care unless he or she requires the services of a nurse, or a physiotherapist, or an occupational therapist, or a respiratory therapist in addition to other support or professional services.)

The Interdepartmental Committee therefore recommends that in developing service coordination beyond coordination of existing services, the home care program should concentrate on developing nursing, homemaking and volunteer services. As the need for further services becomes apparent, they should be added to the program as resources become available. For instance, attendant care, physiotherapy and occupational therapy are among the options for expanded services.

The Department of Social Services has recently begun to provide 75% of the cost of a pilot attendant care program. This pilot program is expected to run for three years. This program provides three hours of attendant care daily to 12 disabled persons in their own homes, at an estimated annual cost of $7,600 per person ($632 per month). This is lower than the cost of a nursing home, but preliminary indications are that three hours per day may not be sufficient and more attendant care may be required. Given the uncertain levels of service and expenditures

required, the committee recommends that at the end of the trial period, the results and effectiveness of the pilot program should be evaluated and a decision made how best to provide care for the disabled.

It should be noted that in concentrating upon the development of nursing and homemaking, the program would be providing more services than is at first apparent. Many homemaking agencies do not only perform housekeeping duties but, thanks to the Home Life Supports Program, also provide a variety of services, shown in Appendix 2.

In order to ensure that the entire Province will benefit from the two services of nursing and homemaking, it will be necessary to promote the creation of homemakers agencies, or at least the provision of homemakers services in the following municipalities:

- Cape Breton County
- District of Shelburne
- Victoria
- Canso
- Louisbourg

a) The role of volunteers

Even if most clients' needs are met by the combination of homemaking and nursing services, the real difference to the quality of the clients' life will be made by the services of the volunteers. Development of the volunteer services was stressed as essential at all the public hearings. Without volunteers, it is unlikely that meals on wheels could function properly, elderly people might feel insecure in their homes because they did not receive a friendly call or visit, and housebound people living alone would not be able to find transportation to doctor's appointments.

Consequently, one of the major tasks of the program's field or local representatives will be to stimulate the volunteer effort and to promote a coordinated volunteer effort. In the public hearings, participants affirmed the need not only to recruit volunteers, but to give them direction, and also to instruct organizations how to employ volunteers. Above all, volunteers should be given recognition for the services they have performed and encouragement to continue. In these respects, the home care program may wish to consult the Volunteer Bureaus of New Brunswick, which have proven successful in developing volunteer services. Fredericton, for instance, even has a volunteer homemaker agency. Several organizations at the hearings mentioned that they could probably obtain more volunteers if there was some consideration of, say, the gasoline they used in transporting seniors to medical appointments. In New Brunswick, one of the methods of remuneration used is to

provide volunteers with receipts indicating the amount of his or her personal money the volunteer has spent performing services for the volunteer agency. Since the volunteer agency is a registered charity, these receipts are then valid for deductions from income tax. Again, this practice should be studied to determine its feasibility.

b) Services provided by Hospitals

Some hospitals have pioneered various in-home services in their catchment areas. These services include renal dialysis, oxygen, elemental food, and home visits by staff, such as laboratory technicians collecting samples and, on the Eastern Shore, an occupational therapist. These services represented about $800,000 in expenditures in 1985-86. Thus, while the Interdepartmental Committee does not recommend the implementation of a purely hospital-based program, it does recommend that the existing hospital-based home care services should be coordinated in the early, if not necessarily the first, stages of the provincial home care program. It also recommends that certain hospital-based services should gradually be added to the home care program as demand indicates and resources become available.

Assessment for Service: General Considerations

a) Organization of Assessment

A theme recurring through all the public hearings was that, as far as possible, **the assessment function of a home care program funded by government should be separated from the delivery function.** Thus, the agency responsible for providing a service should not also be responsible for assessing how much service is to be provided; as was put bluntly by some participants, this would simply allow that agency to write its own cheques against the Provincial Treasury. The assessor is accordingly not just responsible for determining the eligibility of applicants for home care but also for ensuring that care is delivered in the most cost-effective manner. Clearly, in a home care program, if human and financial resources are spent in providing an excessive level of service to some clients, other clients may not be able to benefit from home care, because there are not enough resources to go around.

In Nova Scotia, it may not be possible to separate the assessment and delivery functions absolutely. This complete separation does occur in one of the structural options considered below. It would, however, require new staff and one of the Interdepartmental Committee's chief considerations in the present time of fiscal restraint has been to make use of existing human resources as far as possible. Therefore, in two of the structural options, homemakers agencies retain their current responsibility for assessing the eligibility of applicants for

homemaking services. Except in metropolitan areas, the homemaker agencies are usually the only agency in the municipality providing this type of service, and it would accordingly be difficult to divide assessment and delivery functions between two agencies in the same region.

On the other hand, more than one nursing agency, whether governmental or non-governmental, does exist in areas which include over 60% of the population of the Province. There are about 150 Community Health Nurses (CHNs) stationed throughout Nova Scotia, even in areas where the Victorian Order of Nurses is, by agreement, responsible for delivery of care. The chief functions of CHNs are preventive and educational, but some 17% of their time on a province-wide average is spent coordinating and delivering health care at home. The Interdepartmental Committee considers that the logical approach to health assessment for home care, short of employing entirely new staff, is to employ the CHNs as the assessors who determine the levels of care eligible applicants should receive. The CHNs are distributed throughout the Province (see Chapter 2, Map 1) and are, furthermore, government employees and as such sensitive to the need to employ limited financial resources to greatest effect and benefit. In the regions where CHNs are responsible for the actual delivery of health care at home, they would continue to do so, unless the time required to deliver care as well as assess applicants began to make severe inroads on the time they had available for their primary preventive and educational roles. At that point (and perhaps even before) it might become necessary to explore other means of health care delivery in those areas, such as contracting out to a nursing agency, or employing hospital nurses part-time. In the areas of the Province currently served by the Victorian Order of Nurses, the Interdepartmental Committee recommends that the VON continue to deliver care, while the assessment of clients and determination of the level of service to be provided should be performed by the Community Health Nurses. The City of Halifax has adopted this division of responsibility in its home care program and is satisfied that it works well.

b) Assessment Criteria

Apart from stressing the need to separate the assessment and delivery functions as far as possible, the Committee believes certain other general considerations should guide those responsible for developing the assessment function in the home care program.

First, it is essential to develop effective criteria for admission to the home care program and to develop assessment forms that enable assessors to determine whether a client meets the criteria.

Secondly, in assessing applicants who live with their families, or in locations where family members are readily available to help, the assessors must determine whether the family members are willing and able to provide that help. Apart from caring for people living alone, the home care program will support relatives and friends who are caring for people in their own homes. An important function of the program will be to provide respite care, thus giving a well-deserved rest to family members who are actively caring for their relatives. On the other hand, the home care program must not become a means whereby family members can avoid their obligation to help infirm or elderly relatives. A homemaker from the home care program should not be employed to do the cleaning and other tasks which could be done by an able-bodied member of the household. Home care programs in other Provinces have declared that willingness of family members to help where they can is one of the criteria determining eligibility for admission to the home care program. Nova Scotia should do so too.

Thirdly, the assessor is assessing not only the applicants' need for the program but also the level of service to be provided to clients once accepted. Since an objective of the program is to help clients to achieve the greatest degree of independence possible, the assessor, in determining the level of service, should prescribe **the minimum level of service compatible with the clients' health and well-being.** Although this seems harsh at first sight, further reflection will reveal why Evelyn Shapiro and home care programs in other parts of Canada believe this condition to be absolutely essential to prevent clients from falling into a state of dependency upon the program. Quite apart from the waste of resources, it is damaging to a client's independence and self-respect to have program staff perform tasks which he or she is able to do unaided.

In determining an applicant's suitability for home care, the cost of providing service must be considered. The Committee believes that, in general, an applicant should not be admitted to the program if the cost of providing home care to him or her would exceed the cost of institutional care.

It is likely that, while the program is in its initial stages, there may not be sufficient resources to serve all duly qualified applicants. One of the criteria for admission will therefore have to be availability of resources. For instance,the program could be restricted to clients who require no more than a certain number of visits per day week or month. This conforms to practice in Ontario and St. John's, Newfoundland.

In most programs across Canada, the assessors themselves make the decision to admit applicants to the program. In difficult cases, the assessors refer the case to a committee or to the Executive Officer of the home care unit. In Nova Scotia, such cases could be referred to a committee composed of the

manager of the homemaking agency and the supervisor of Community Health Nurses in the district health unit. Further appeals could be directed to the Home Care Division office in Halifax.

The assessor will usually be the case coordinator who draws up the care plan for the client. Most home care programs require the client to give his or her assent to this plan. This practice should be followed in Nova Scotia. Again, any irreconcilable disagreements should be subject to the appeals process.

Finally, the job of the assessor/case coordinator does not end with the development of a care plan and the initial contacts he or she makes with the care providers. The case coordinator must remain in contact with the care providers concerning the condition of the client and must visit the client regularly to reassess the situation. The client's health may improve or deteriorate, necessitating changes in the levels of health care to be provided. The St. John's Home Care Program reasesses clients requiring chronic care every three months, and clients requiring acute care much more frequently.

VI. STRUCTURE

The structure of a coordinated home care program should promote coordination at three levels:

i) central coordination
ii) local coordination
iii) case management.

To provide these levels of coordination, the Interdepartmental Committee considered three structural options in depth:

1) a Home Care Coordinating Agency that provides integrated coordination of all home care services
2) joint coordination by the Community Health Division of the Department of Health and a Home Care Division in the Department of Social Services
3) a Home Care Agency separate from other government departments.

In the first option, the central coordinating agency is a committee of government ministers whose departments are closely involved in the delivery of home care services. In the second option, two government departments are chiefly responsible for coordinating home care. In the third option, the agency is distinct from any existing department and reports to its own minister.

The first two options employ Field Representatives to develop coordination between local organizations providing in-home service. In the third option, managers of local units of the home care agency perform the same function.

In the first two options, assessment of applicants for home care is performed by the staff of existing agencies: staff of the homemakers agencies would undertake assessment of applicants' need for homemaking and other social services, while Community Health Nurses would assess applicants for health care. The two assessors would work as a team, and each would coordinate the services in the areas of his or her expertise. In the third option, the assessor/case manager of the local unit would perform the social assessment, and the local Community Health Nurse would perform the health assessment. All services, however, would be coordinated by the assessor/case manager.

The first two options differ in the responsibilities assigned to the Departments of Health and Social Services and also in the department responsible for paying for service. In the first option, the Home Care Agency's administration, located in the Department of Social Services, is responsible for paying for or funding the delivery of all services. In the second option, the Department of Health assumes the cost of delivering home health care, while Social Services funds homemaking and volunteer services. In the third option, the separate home care agency is responsible for funding both health and social services.

All three options are community-based, rather than hospital-based; that is to say, the services are coordinated, and to a large extent delivered, by an agency in the community, rather than by staff based in a hospital. Hospital-based programs of various kinds exist in other jurisdictions, and certain hospitals in Nova Scotia have proposed hospital-based home care plans to the Department of Health and also raised the matter in the public hearings. On the other hand most participants in the public hearings were solidly opposed to a hospital-based program, on the grounds that it would tend to be 'illness-oriented' rather than 'health-oriented'. This means that it is thought that a hospital-based program would tend to concentrate on curing illness, rather than on preventing it. Among some people, there may have been a fear that clients could only gain entrance to a hospital-based program if they showed a need for some health care service. Since the vast majority of participants in the hearings felt that a home care program should be able to coordinate in-home social services independently of in-home health services, this was another mark against a hospital-based program.

Consideration of each of the options for the administrative and delivery structure for the home care program has been organized under the following headings:

a) nature of central coordinating agency
b) nature of local agency responsible for coordinating assessment and professional and voluntary service organizations
c) nature of case management, i.e., what person coordinates the services to the individual client
d) payment of services
e) nature of public participation in the program, in an advisory or delivery capacity
f) advantages and disadvantages.

Costs and fees are discussed in Chapter VI.

1. Home Care Coordinating Agency

a) Central Coordinating Agency

i) Coordinating Structure

The central element of the Home Care Coordinating Agency is the committee composed of the Ministers of Health, Housing, Municipal Affairs and Social Services (see Table 12). Health, Housing and Social Services are the principal departments involved in the provision, coordination and funding of existing home care services. Since the most widely used services in a home care program are homemaker services, which are the responsibility of the Department of Social Services, the Minister of Social Services should chair the Committee. Many homemaker agencies receive significant funding from municipal governments, and the increased responsibilities both in assessment for and

delivery of service in the home care program may well lead to increased demand for funding from the municipalities. Given the important role that Municipal Affairs plays in municipal financing, it is essential that the Minister of Municipal Affairs should be a member of the Ministers' Committee, so as to ensure good relations with the municipalities regarding financial arrangements and other home care matters. Ministers of other departments can be associated with the committee as the need for their participation is identified.

The chief responsibilies of the Ministers' Committee are the development of home care policy and the coordination of the home care services delivered or administered by all government departments. It is essential that a group of ministers be associated in the direction of home care, to ensure that all major decisions are taken at the highest level and to ensure immediate compliance with the Agency's decisions.

The specific responsibilities of the Ministers' Committee are

i) review and approval of overall policy
ii) review and approval of departmental program responsibilities
iii) public accountability for the direction of the home care program
iv) approval of, and agreement on funding for home care by each department.
v) appointment of the Advisory Committee.

Responsibility for preparing the agenda for the Ministers' Committee and for supervising the execution of the Ministers' Committee's decisions lies with the Deputy Ministers' Committee on Coordinated Home Care. This Committee consists of the Deputy Ministers of Health, Housing, Municipal Afairs and Social Services and the Provincial Coordinator of Home Care.

The Deputy Ministers' Committee will consult with a Home Care Advisory Committee. The Home Care Advisory Committee will be composed of representatives of professional organizations, homemakers agencies, volunteer groups (such as the Royal Canadian Legion and churches), groups representing persons served by home care, such as the disabled and seniors, and other interested organizations. This Committee will enable these organizations to provide the Deputy Ministers' Committee with informed comment on their particular areas of expertise.

The Deputy Ministers' Committee can draw on the services of the staff of their respective departments to work on specific interdepartmental issues related to home care, as the need arises.

Day-to-day administration and the delivery of home care are the responsibilities of the Home Care Coordinating Agency's administration, located in the Department of Social Services.

This administration is headed by the Provincial Coordinator of Home Care, of Executive Director rank. He or she reports to the Deputy Minister of Social Services. The Provincial Coordinator's role is to work with the Deputy Ministers' Committee, under the guidance of the Ministers' Committee, and with input from the Home Care Advisory Committee, to initiate and administer coordinated home care services in Nova Scotia.

The Coordinator will require a small but capable staff, consisting of

- an Assistant Coordinator
- a Statistical Clerk
- Director of Homemaker Services
- Seven Field Representatives
- clerical support

The Assistant Coordinator will aid the Provincial Coordinator in most of the functions detailed in (ii) below. he or she will also be responsible for research and data processing, assisted by the Statistical Clerk.

The Director of Homemaker Services should be transferred from the Family and Children's Services Division in Social Services to the new Home Care division and should report to the Provincial Coordinator. The Director's present task is to develop and supervise homemaker agencies in the Province and this should continue. He will take a leading role in negotiating levels of service to be provided to the new home care program by the agencies. He will also be responsible for developing new homemaker agencies where they do not now exist and for maintaining homemaking standards.

The Field Representatives will be assigned to each one of the Social Services districts in the Province and their main responsibility will be to liaise with the delivery agencies in their respective areas (see below).

ii) Development and Administration of Coordinated Home Care Services

The Ministers' Committee will review and approve general policy guidelines for home care. The Provincial Coordinator must ensure that general policies, standards of care, protocols to ensure cooperation between care givers and reporting procedures are developed by the Home Care Administration. These developments will occur partly as a result of work by Home Care administration staff, who will seek advice from outside government where necessary, and partly as a result of negotiations with other governmental and non-governmental agencies.

Health Care

The Provincial Coordinator will have to work closely with the Department of Health, and with the Community Health Division

in particular, in the development of policies, standards and procedures for in-home health care. As a start, the Deputy Ministers' Committee must reach an agreement with the Department of Health concerning the availability of Community Health Nurses and CNAs for the program. The Provincial Coordinator will then work closely with the Director of Community Nursing to establish the staffing arrangements at the local level. The Interdepartmental Committee recommends that assessment for home care should be included as one of the CHNs' regular duties. For actual delivery of care by CHNs and CNAs, however, the Department of Health will bill the Home Care administration.

In much of the Province, the Victorian Order of Nurses and other nursing agencies, such as Comcare, will be responsible for delivering home nursing care. Negotiations will have to be undertaken with these agencies concerning levels of service and rates of remuneration. The Department of Health's expertise in negotiating with nursing agencies will be available to the Deputy Ministers' Committee which will be responsible for negotiating with the agencies. The Provincial Coordinator will then be responsible for the day-to-day working relationship with the agencies. Payments for delivery of nursing service will be made by the Home Care Administration.

The Deputy Ministers' Committee will also have to negotiate with the hospitals to arrange for the integration of the home services they currently provide into the home care program.

Relations with Municipalities

The Deputy Ministers' Committee should negotiate with the municipalities to ensure their cooperation and their support of the program. The Cities of Halifax and Dartmouth should be approached so as to arrange that their current home care coordination agencies continue as the local centres for assessment and coordination in each city. The Provincial Coordinator and other staff will have to work closely with municipal officials to ensure the smooth operation of the coordinated system.

Homemakers Services

It is recognized that the cooperation of existing homemakers agencies will be essential to the success of the home care program. The Provincial Coordinator, acting in close cooperation with the Deputy Ministers' Committee, and with the assistance of the Director of Homemaker Services, will have to negotiate with the homemaker agencies concerning their participation in the home care program and their new function as local coordinating agencies.

Since the role of homemaker agencies specializing in serving families at risk is somewhat different from that of other homemaker agencies, the Provincial Coordinator and the Director

of Homemaker Services will have to negotiate with the agencies serving families at risk to determine the nature of their involvement with the home care program.

In certain localities, the Provincial Coordinator (through the Director of Homemaker Services) will have to initiate development of homemaker agencies where they do not now exist. Some of these agencies may be private, some municipal.

Volunteer Services

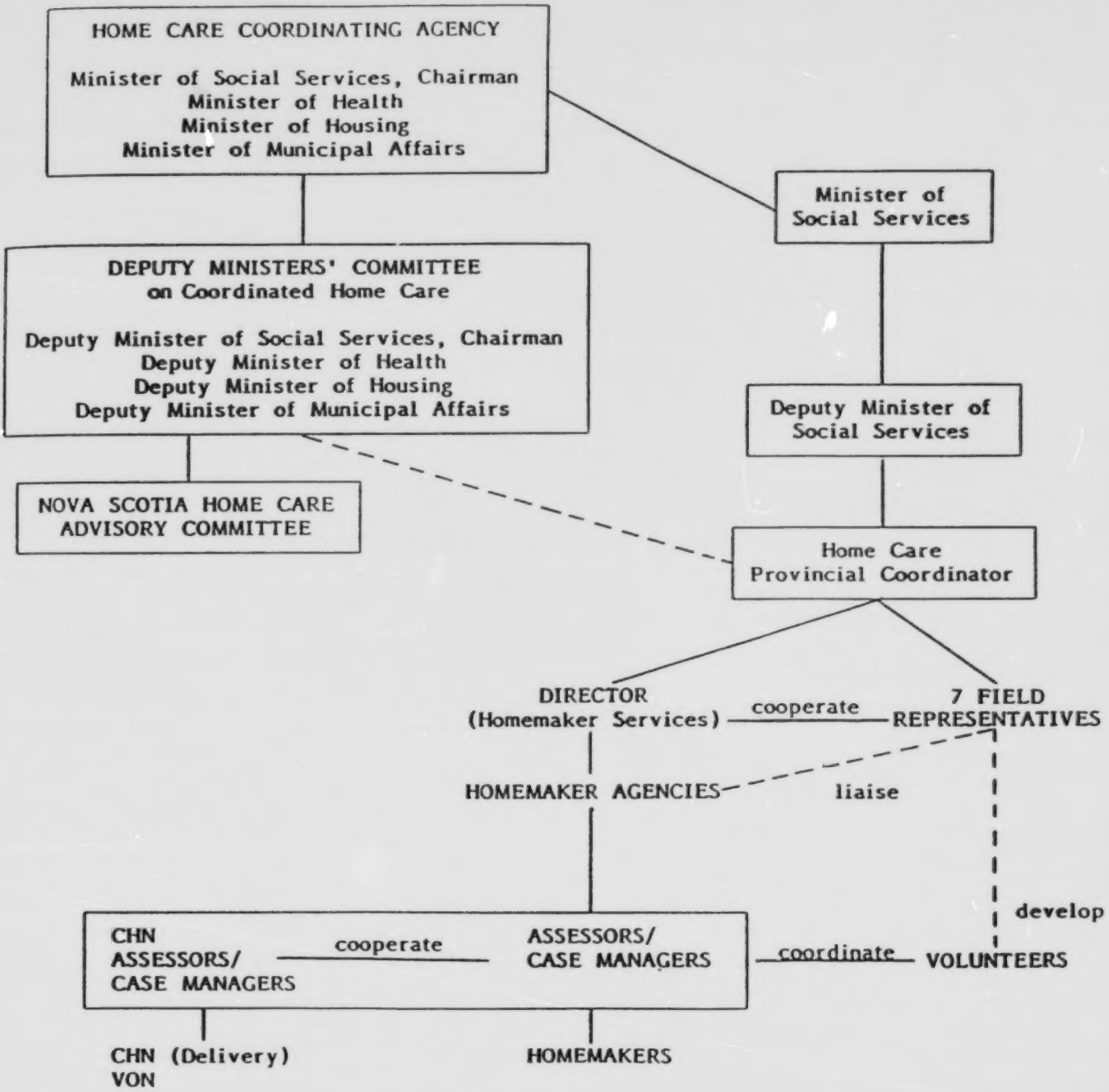
The Provincial Coordinator, with direction from the Ministers' and the Deputy Ministers' Committees, should negotiate with Provincial and local volunteer organizations and agencies to ensure their participation in the provision of home care services. With respect to local organizations, responsibility for making the initial arrangements and subsequently, for ensuring a smoothly functioning relationship, will fall to the Home Care Administration's field staff. The Home Care administration will have to encourage the participation of volunteer organizations and agencies in the program, and the development of volunteer agencies in some areas. This will be done chiefly through the services of the Field Representatives (see below).

Resource and Supervisory Services

Once the program is in operation, the Coordinator will have to monitor the effectiveness of delivery in the various parts of the Province. To do this will require the development of performance indicators, which will be one of the major responsibilities of the Assistant Coordinator and the Statistical Clerk.

The officials responsible for ensuring the smooth functioning of the system will be the Field Representatives. Each will be assigned to one of seven Social Services Districts in the Province. Their main responsibility will be to liaise with the delivery agencies in their respective areas providing advice and assistance and promoting harmonious relationships between the various agencies. Thus, the Field Representatives, after consultations with the Provincial nursing organizations, will be responsible for maintaining contacts with the local offices of the nursing services to ensure that agreements made at the provincial level run smoothly. Where there is more than one homemaker agency serving a given municipality (this is rare outside the urban areas) the Field Representatives will ensure that the agencies cooperate concerning each one's service area and quantity of service. The Field Representatives will also be responsible for developing volunteer agencies to perform services that were lacking in their area. Once the program is in operation, they will be directly responsible for monitoring the effectiveness of the program at the local level, through contacts and consultations with care providers and recipients and the general public.

TABLE 12
OPTION 1: HOME CARE COORDINATING AGENCY



COMMUNITY HEALTH NURSES (CHN'S) CONTINUE TO BE TIED TO HEALTH SYSTEM

b) Local Coordination

In this option, the local coordinating agencies are:

a) the existing homemaker agencies
b) the existing home care coordinating agencies in the cities of Halifax and Dartmouth
c) in the municipalities of Cape Breton County, District of Shelburne, Victoria, Canso and Louisbourg, newly created homemaker agencies or homemaker agencies in adjoining municipalities which will agree to expand their services through a cost-sharing agreement with the municipalities currently lacking homemaker services.

As the local coordinating agencies, the homemaker agencies will be responsible for maintaining contact with local volunteer agencies and other providers of social-service-type home care. They will also be expected to maintain close contact with the local Community Health Nurse. The Field Representatives will assist the homemaker agencies in developing, maintaining and enhancing these linkages.

Each of the agencies identified above will become the single entry point for home care in its region. Each will have a toll-free number for applicants for home care to call, or for referrals of clients being discharged from hospital. (Since the homemakers are expected to work closely with the CHNs, applicants can also call the local Community Health office, which will then discuss the application with the homemaker agency, to determine whether the application should be considered and, if so, what type of assessment is appropriate.)

c) Assessment and Case Management

Homemaking agencies currently assess applicants for homemaking services; this is also done by staff from the Halifax and Dartmouth home care programs. At present, Community Health Nurses are responsible for assessing and providing services for persons requiring in-home health care in those regions where the CHNs are responsible for the delivery of home nursing care.

In the City of Halifax home care program, a Community Health Nurse is associated with the Home Care Coordinator in the assessment process. The applicant's care needs revealed by initial contact determine the type of assessment to be made. Most frequently, the Home Care Coordinator and the Community Health Nurse visit applicants together to perform assessments. Otherwise, where an applicant for home care appears from initial contact to need only social or homemaker services, the Home Care Coordinator performs the initial assessment. (The Coordinator performs most initial assessments.) Where initial contacts seem to indicate that only health care is required, the CHN performs the initial assessment. If the CHN health assessor feels that further social assessment is required, the Home Care

Coordinator is contacted to perform this assessment, and vice-versa. After assessment and development of a case plan, the Home Care Coordinator coordinates the delivery of service. At present the Coordinator is responsible for coodinating both health and social services, but there are indications that health coordination could be performed more effectively in certain cases by the CHN. Both assessors reassess the client regularly.

The City model is similar to that employed by various home care programs across Canada. Discussions with their executive staff indicate that it is fairly simple to determine from the initial phone call or application for home care whether the applicant will require a health assessment as well as a social service one. There is no need for the assessors to go everywhere together, since the health assessor is usually capable of determining whether the applicant should be referred to the homemaking assessor, and vice-versa.

The Interdepartmental Committee believes that the concept of an assessment team similar to the City model, with the Community Health Nurse cooperating closely with the homemaking agency to perform assessments, is the model that should be employed across Nova Scotia.

In each area, a homemaking agency should be designated by the Provincial home care program as the designated agency for coordinating assessment for and delivery of social-service-type home care in that area. Each designated agency would accordingly perform a role similar to that of the City of Halifax home care program.

The designated homemaker agencies would therefore have to come to a working relationship (where they have not already done so) with their local Community Health Nurses. Furthermore, the Department of Health should mandate Community Health Nurses to perform home care health assessments and care coordination in cooperation with the homemaker agencies as part of their required duties.

Cooperation between homemaker agencies and Community Health Nurses could occur as in table 13.

d) Payment of Services

In this option, the Home Care Coordinating Agency administration located in the Department of Social Services is responsible for funding the delivery of services. Thus Provincial funding of homemaker agencies is included in the Home Care Agency's budget. Any recoveries from charging for homemaker services are set against the Agency's expenditures on homemakers.

Time spent on health assessments by the Community Health Nurses as part of their duties will be funded by the Department of Health. The cost of the delivery of nursing care by the Community Health Nurses will, however, be paid by the Home Care Agency Administration, through a chargeback.

TABLE 13

ASSESSMENT PROCEDURE FOR HOMEMAKER AGENCY AND COMMUNITY HEALTH NURSE

A. Initial contact with homemaker agency

Homemaker Agency	Community Health Unit
Where initial contact is made with the homemaker agency, and no health services seem to be required,	
1) A social assessment will be completed by a homemaker assessor to determine what social services are to be provided.	
2) The assessor will coordinate social services for eligible clients.	
3) If the assessor deems a health assessment is required,	
A referral will be made to the local Community Health office on an appropriate referral form. Client should be informed of the referral. If case is urgent, call by phone and follow up with referral form.	
	4) Community Health Nurse will contact client.
	5) Carry out health care assessment. Family physician contacted for medical orders, if required.
	6) Coordinate health services, if required.

7) Inform homemaker agency in writing whether or not health services are being provided to client.

8) Record for statistical information.

9) Inform homemaker agency in writing of increases or decreases in level of health care provided client receiving social services.

10) Record information.

B. Initial contact with Community Health Unit

Community Health Unit	Homemaker Agency
1.a) When initial contact is made by medical referral/hospital liaison, Health Unit will determine if health services are to be provided.	
b) When initial contact is from the community and does not appear to have a health need - direct referral to homemaker agency using referral form and designate that information was received by phone.	
or	
If health needs are apparent - a health care assessment will be completed. Family physician will be contacted for medical orders, if required.	
2) For all referrals, Community Health Unit will identify if a social assessment is required	

and will refer individual to homemaker agency on the referral form. Client should be informed of the referral. If case is urgent, call by phone and follow up with referral form.

3) Homemaker agency contacts individual.

4) Carry out a social assessment.

5) Coordinate social services, if necessary.

6) Inform Community Health Unit in writing whether or not social services are being provided to clients also receiving health care.

7) Record information.

8) Inform Community Health Unit in writing of increase or decrease in level of social service (homemaking or meals, say) being provided to clients also receiving health care.

9) Record information.

Likewise, the cost of delivery of nursing care by other nursing agencies, such as the VON or Comcare, will be met by the Home Care Agency. It will be necessary for the Agency to come to an arrangement with these agencies concerning the hourly cost of service.

e) Public Participation

In this structure, public participation occurs both formally and informally.

First of all, there is the formal Home Care Advisory Committee which the Deputy Ministers Committee on Home Care can consult on the subject of home care. As mentioned above, this Committee is composed of representatives of the medical and nursing professions, homemaker agencies, the Royal Canadian Legion, church and volunteer groups providing care or involved in care. There should also be representatives of people receiving care, such as members of senior citizens organizations, the mentally ill and the disabled. This Committee will enable these organizations and professions to provide informed comment in their particular areas of expertise.

Each Field Representative will consult members of the care giving organizations and professions in his or her region. He or she may do so either through formal meetings or through more informal channels. It is expected that the Field Representatives will serve as troubleshooters, to whom not only persons providing care but also recipients of care and members of the general public will be able to express their concerns. Conversely, an important task of the Field Representatives is to explain the program to care providers (especially to physicians, to encourage them to refer to the program) and to the general public.

Homemaker agencies frequently have boards drawn from the local community. These boards can effectively represent local concerns to the agency. In addition, the agencies' close contact with voluntary agencies enables them to keep their finger on the pulse of community opinion.

f) Advantages and Disadvantages

A new Home Care Coordinating Agency with its administration located in the Department of Social Services is the Inter-departmental Committee's preferred option, for the following reasons:

i) The program makes maximum use of existing services, administrative structures and financial arrangements.

ii) The Ministers' Committee, drawn from the Departments of Health, Housing, Municipal Affairs and Social Services, and from other departments as necessary, assures broad and effective cooperation across government in the provision of home care services.

iii) Social Services is the preferred department for location of the administration and delivery of the program, since comparisons with other provinces indicate that homemaking, currently Social Services' responsibility, is the most frequently used service in a home care program.

iv) This structure causes little disruption to present patterns of delivery and existing linkages between service providers. Thus, this option employs homemakers as assessors for non-health home care, rather than employing entirely distinct assessors. Since homemakers currently do this sort of assessment this can be seen as the most appropriate approach.

v) Centralization of responsibility for home care administration in a single department avoids confused lines of reporting and the uncoordinated policy and service development that could occur if responsibility for the program was divided between two or more departments.

vi) At the same time, incorporation within an existing department and utilization of existing service delivery structures ensure that costs are controlled more effectively than they would be if an entirely separate home care agency were to be created. A completely separate agency, especially one that would have to establish new local units, would incur more additional expenses than the administration located in an existing department, a department which already covers some of the responsibilities and overheads a completely separate agency would incur.

vii) The organizational structure assures coordination at the provincial, local and individual levels.

viii) Creation of a Home Care Coordinating Agency and the establishment of the Agency's administration as a separate entity within Social Services ensures that the Agency will be clearly visible to the public as a government program targeted upon home care.

ix) The principal entry point in this option is through the homemakers agency. Since the homemakers and Community Health Nurses will work closely together as an assessment team, initial contacts with the CHNs will be brought to the attention of the homemakers.

x) The structure provides for the future growth and expansion of services.

xi) The structure provides for maximum use and promotion of volunteer services.

The disadvantages of this option are

i) While the homemakers agency is the principal entry point, it is not the single entry point, since initial contact can be made with the Community Health Unit. Since, however, there will be established procedures ensuring cross-referral of applicants between the homemakers' agencies and the Community Health Unit, this should not cause difficulty to the applicant. Indeed, maintenance of the Community Health Unit as one of the possible (though not the principal) entry points causes the least disruption in the present pattern of health referrals: hospital discharge planners are accustomed to discharging patients to Community Health Units, and this practice can continue.

ii) Some homemaker agencies may not have the resources to enable them to act as local coordinators of the program.

2. Joint Coordination by the Community Health Division of the Department of Health and a Home Care Division in the Department of Social Services

a) Central Coordinating Agency

i) Coordinating Structure

In this option, the central coordinating agency for policy is a Home Care Coordinating Committee consisting of the Deputy Ministers of Health and Social Services, and of appropriate senior staff from the Community Health Division of Health and a new Home Care Division of Social Services. This Committee could draw staff from each department and from the rest of government to form subcommittees charged with working on specific policy issues. A Home Care Advisory Committee, as in Option 1, provides informed comment to the Coordinating Commmittee.

In Social Services, a new Home Care Division headed by an Executive Director roughly equivalent to the Provincial Coordinator in Option 1 would be created. (See Table 14). The staff and their assigned roles would be generally the same as those of the Home Care Agency administration in Option 1, with the Director of Homemaker Services reporting to the Executive Director, and the other head office senior staff and field representatives having the same responsibilities as in that option.

In the Department of Health there should be a Home Care Coordinator in the Community Health Division, though the task could well be performed by the Director of Community Health Nursing unless the home care workload increased to the point where it conflicted with her present responsibilities. She would be responsible for supervising and coordinating health home care services.

The Executive Director of Home Care and the Home Care Coordinator cooperate both directly and as members of the Home Care Coordinating Committee.

ii) Development and Administration of Coordinated Home Care Services

The Executive Director heads the Home Care division in the Department of Social Services. He or she reports to the Deputy Minister of Social Services. The Executive Director's role is, first of all, to initiate the coordination of home care services in Nova Scotia.

The Executive Director must ensure that general policies, standards of care, protocols to ensure cooperation between care givers and reporting procedures are developed by the Home Care Division. These developments will occur partly as a result of work by Home Care division and other government staff, who will seek advice from outside government where necessary, and partly as a result of negotiations with other governmental and non-governmental agencies.

The Executive Director will have to negotiate with the homemaker agencies concerning their participation in the home care program. In Halifax and Dartmouth, the Director will have to negotiate with the municipalities concerning the extension of their coordinated home care programs. Elsewhere, the Executive Director (through the Director of Homemaker Services) will have to initiate development of homemaker agencies where they do not now exist.

Similarly, the Executive Director will have to encourage the participation of volunteer organizations and agencies in the program, and the development of volunteer agencies in some areas.

Once the program is in operation, the Executive Director will have to monitor the effectiveness of delivery in the various parts of the Province. To do this will require the development of performance indicators.

The Home Care Coordinator in the Department of Health will be responsible for supervising and coordinating health home care services. Thus the Coordinator will ensure that Community Health Nurses cooperate with homemaker agencies in assessing and coordinating home care services at the local level. She will take a leading role in negotiating fees and levels of service with the nursing agencies delivering care in areas where care was not delivered by CHNs. She will also liaise with hospitals to maintain the institutions' current provision of home health care and to encourage them to provide more.

As in the preceding option, Field Representatives from the Home Care Divison will be responsible for liaising with, assisting, promoting and monitoring local delivery agencies. In this option they will play an especially important role in maintaining contact between health and social service types of home care. They will report directly to the Executive Director of Home Care in Social Services, but should keep the Home Care Coordinator in Health informed of local conditions.

The chief differences between this option and Option 1 are:

- responsibility for the home care program is assigned to the Departments of Health and Social Services only, not to a broadly based interdepartmental Home Care Coordinating Agency

- the roles of the Departments of Health and Social Services are more distinct than in Option 1; rather than having a Home Care Coordinating Agency administration which, though located in the Department of Social Services, is also responsible for funding home health delivery, Option 2 assigns responsibility for coordinating and funding home health services to the Department of Health, and responsibility for coordinating and funding social-service-type home care to the Department of Social Services

- the Home Care Coordinating Committee, consisting of Deputy Ministers and senior staff, becomes the principal agency ensuring interdepartmental cooperation, but negotiations with health and social service providers are undertaken by the respective departments, through the Executive Director of Home Care and Health's Home Care Coordinator.

b) Local Coordination

In this option, there would be two local coordinating agencies: the local homemaker agencies and the local office of the Community Health Unit. The homemaker agencies would coordinate social services, and the Community Health offices would coordinate health services. Initial contact could be made with either; there would thus be two entry points to the system. Protocols for exchange of information and coordination of services should be established as in Option 1, Table 13.

As in Option 1, the homemaker agency would be responsible for maintaining contacts with voluntary agencies providing social services, and the Community Health Unit for maintaining contacts with health care providers, such as nursing agencies, Arthritis Society and hospitals.

c) Assessment and Case Management

Assessment and case management would be performed as in Option 1.

d) Payment of Service

In this option, the Department of Health pays for the delivery of health services; the Department of Social Services funds the delivery of homemaking and other social services, as necessary.

As in the first option, the Home Care Division in Social Services will be responsible for funding the homemaker agencies. Any recoveries from fees for homemaking will be set against the Department's outlays.

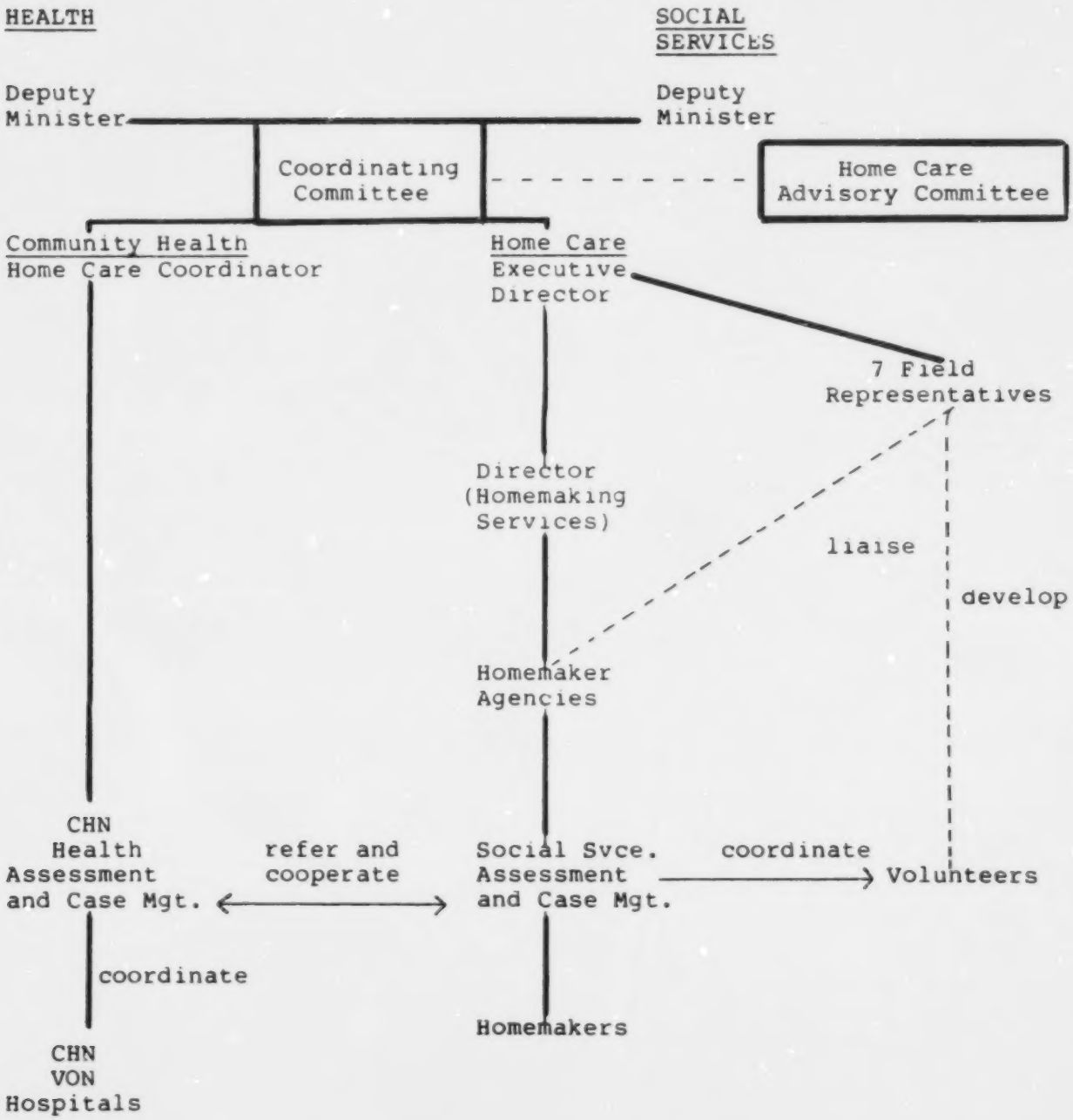
Health assessments and delivery of home nursing by Community Health Nurses will be funded by the Department of Health. The Department will likewise assume the costs of paying for nursing delivered by nursing agencies, and for negotiating hourly rates of remuneration with them. The annual grant to the VON remains in the Department of Health budget.

e) Public Participation

A Home Care Advisory Committee will meet with the Ministers of Health and Social Services and their Deputies to discuss general matters relating to home care. The public representatives should be drawn from care providers, such as

TABLE 14

OPTION 2: JOINT COORDINATION BY HEALTH AND SOCIAL SERVICES



members of the health professions, homemaker, Legion, church and volunteer groups, and from representatives of people receiving care, such as members of organizations of senior citizens, the mentally ill and disabled.

As in Option 1, the Field Representatives would, in addition to promoting voluntary agencies, meet with members of the public to discuss improvements to the program. The Field Representatives would report their findings to the Department of Health as well as to the Home Care Division in Social Services.

Homemaker agencies frequently have boards drawn from the local community. These boards can effectively represent local concerns to the agency. In addtion, the agencies' close contact with voluntary agencies enables them to keep their finger on the pulse of community opinion.

f) Advantages and Disadvantages

The Interdepartmental Committee does not recommend this model of home care, because it would formally create two entry points into the home care program. The structure does, however, have certain advantages:

i) This structure causes the least disruption of existing patterns of service. Homemakers would continue to assess and coordinate services for their clients; Community Health Nurses would continue to assess and coordinate services for their clients; and homemakers and nurses would cooperate and refer clients to each other. This structure would merely formalize what goes on now.

ii) Each department is assigned the field in which it has developed expertise. Thus Health would continue to handle relations with the Victorian Order of Nurses and other nursing agencies, while Social Services could concentrate on developing homemaker and voluntary services and negotiating with the municipalities.

iii) Budgetary control is maintained within larger government departments, unlike Option 3, and, unlike Option 1, there is no disruption of existing patterns of funding. In Option 1, the Home Care Agency administration located in Social Services would be responsible for meeting the costs of delivering nursing care; in this option, these costs would be absorbed in the Department of Health budget.

On the other hand, this option has the following disadvantages:

i) There is no distinct Home Care Agency responsible for coordinating all health and social services in the Province. The new Home Care Division in Social Services could be perceived as simply an expanded version of Homemaker Services.

ii) The record of interdepartmental cooperation in parallel delivery of programs suggests that conflicting departmental priorities could impede smooth operation and development of the program. In Option 1, a central agency assures common policy and coordinated program development.

iii) There would be two clearly separate entry points to the program: the homemakers agency and the Community Health Nurse. In Option 1, the Homemakers Agency is considered the single entry point, because it is chiefly responsible for local coordination; in Option 3 there is a completely separate local health unit as the entry point.

Otherwise, in terms of providing three levels of coordination, ability to expand services and make use of volunteers, there is little to choose between Option 2 and Option 1 (or Option 3, for that matter).

3. A Separate Home Care Agency

a) Central Coordinating Agency

In this option, home care is organized by a separate agency directly responsible to its own Minister (see Table 15).

The civil service head of the agency would be of Executive Director or Deputy Minister level. He or she would be responsible for

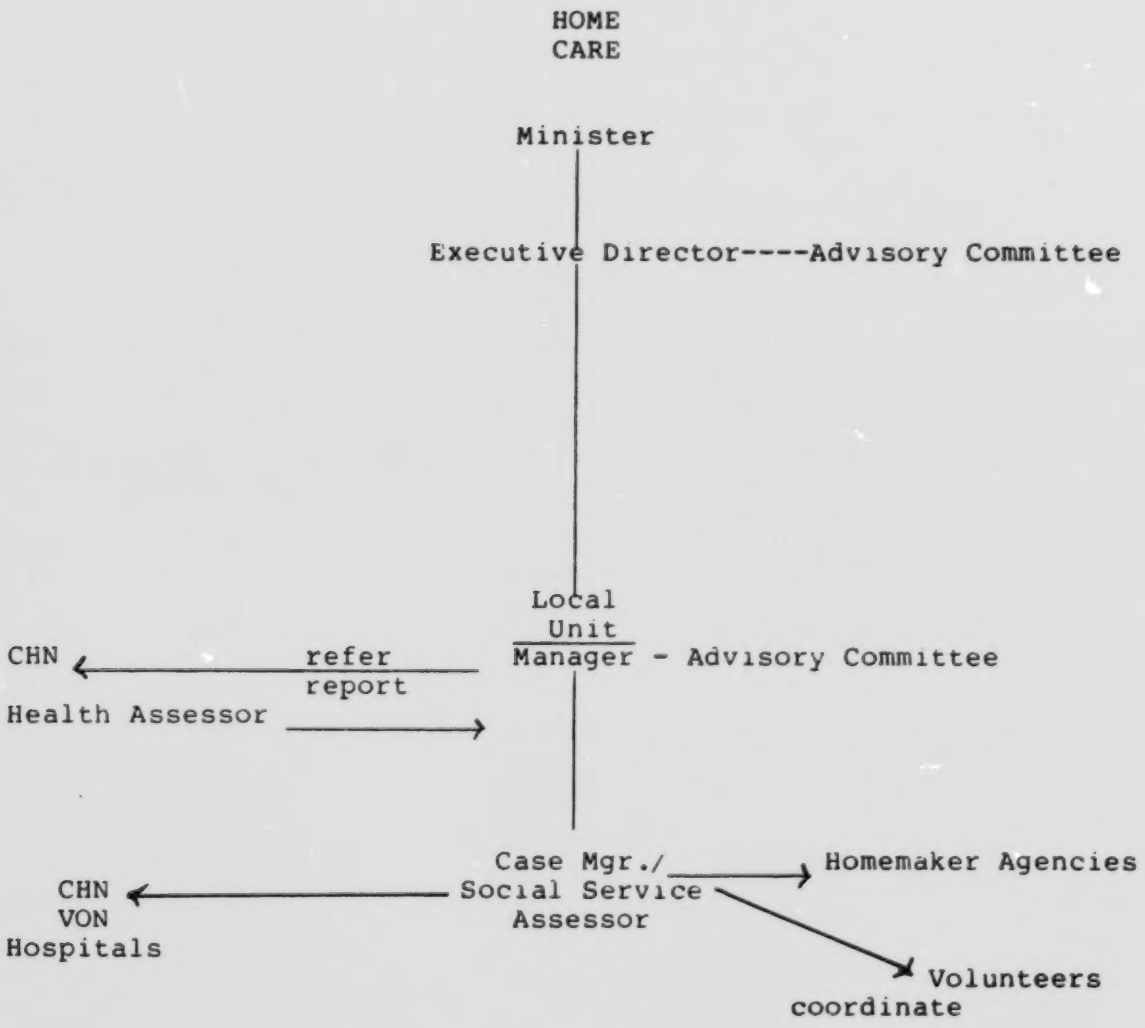
- developing a coordinated home care program
- negotiating availability of, and procedures for, CHNs and CNAs with the Department of Health
- negotiating levels of service, procedures and renumeration with the Victorian Order of Nurses
- negotiating with homemaker and volunteer agencies concerning their participation in the coordinated home care program
- developing general policies, standards of care, protocols to ensure cooperation and reporting procedures
- generally contacting care providers and physicians to encourage use of the program.

Again, since the services of homemaker agencies would all be part of the home care program, the Director of Homemaker Services should be transferred from Social Services to the new home care agency. He would then report to the Executive Director.

Other staff would generally be similar to Option 1's Home Care Coordinating Agency administration: an assistant, a statistical clerk and clerical help. Because, however, this new agency could no longer make use of the existing Financial Services division of Social Services or Health, the agency would have to have a financial services section, headed by a Financial Director. This section would probably require the services of one or two accounting clerks and clerical help.

TABLE 15

OPTION 3: SEPARATE HOME CARE AGENCY



Since the program would be coordinating health services as well as social services, it would probably require the participation of a consulting physician as Medical Advisor. The Medical Advisor would supervise the development of levels and standards of nursing care and of standardized procedures. On the other hand, the agency staff could work with staff from the Department of Health to formulate the levels, standards and procedures.

As in the other options, field representatives would be required, not only to help develop the program, but also to supervise the program once it was in operation. In this case, however, it is expected that the field representatives would subsequently become the local unit managers.

b) Local Coordination

Local offices of the Home Care Agency would be established at regional centres throughout the Province to undertake the regional coordination of home care. The Registered Nurses Association considers that six to eight offices would be required; the Senior Citizens Secretariat estimates 17 (corresponding roughly to one per county); some groups at the hearings suggested that even more would be required to serve subdivisions of counties and municipalities, e.g., Victoria County north and south of Cape Smoky would require one office each.

Unit staff would consist of a unit manager, a social worker/case manager and clerical. The unit manager would be responsible for

- chairing the local advisory committee consisting of care providers
- arranging for services from organizations of care providers (homemaker agencies, Community Health Unit, nursing agencies)
- developing volunteer services
- supervising assessors (in small units, the unit manager herself might perform the assessment)
- liaising with hospital discharge planners, sending health and social assessors to local hospitals to perform pre-discharge assessment, if necessary.

c) Assessment and Case Management

Assessment for health services would be performed by Community Health Nurses. Assessment for homemaking and other social services would be performed by the social worker/case manager on the unit's staff.

Normally, all applicants for, or referrals to, home care would be directed to the local office of the Home Care Agency. In all cases, the social worker/case manager on the office staff

would perform an assessment to determine which social services the applicant required. If the applicant was referred from hospital or by a physician with an indication that health care was required or if, during the course of her own assessment, the social worker/case manager determined that health care seemed to be necessary, the social worker/case manager would contact the local community health nurse to perform the health care assessment.

In this option, the social worker/case manager is responsible for coordinating all home care services. Consequently, as a result of his or her own social assessment, he or she coordinates the homemaking and other social services required. The Community Health Nurse communicates the results of the health care assessment to the social worker and indicates the types and levels of health care required. The social worker/case manager then contacts the deliverers of health care (VON, other nursing agencies, hospitals) to arrange for care to be provided. In areas where care is provided by the Community Health Nurses, the social worker/case manager would probably arrange for care simply by telephoning the health assessor, to ask the Community Health Unit to provide care.

As in the other options, arrangements would be made for reassessing clients regularly (or as necessary), both for health and social services. See Table 16.

d) Payment of Services

In this option the home care agency is responsible for funding the delivery of services. Since the Director of Homemaker Services is transferred to the new agency, Provincial funding of homemaker agencies is included in the home care agency's budget. Any recoveries from charging for homemaker services are set against the agency's expenditures on homemakers.

Time spent on health assessments by the Community Health Nurses as part of their duties will be funded by the Department of Health. The cost of the delivery of nursing care by the CHNs will, however, be paid by the home care agency, through a chargeback.

Likewise, the cost of delivery of nursing care by other nursing agencies will be met by the agency. The agency will have to come to an agreement with these agencies concerning the hourly cost of their services. The annual Provincial grant to the VON could be assumed by the home care agency or could continue in the Department of Health's budget.

e) Public Participation

There should be a Home Care Advisory Committee which the Executive Director could consult on the subject of home care. Representatives of the various organizations associated with the

TABLE 16

ASSESSMENT PROCEDURE FOR SEPARATE HOME CARE AGENCY

Home Care Agency	Community Health Unit
A. Social services only required	
1) Initial contact is made with the Home Care Agency	
2) A social assessment is made by the social worker/ case manager	
3) The social worker/case manager coordinates the social services required	
B. Social Services and health care required	
1) Initial contact is made with the Home Care Agency	
2) During course of social assessment social worker/ case manager determines that health care is required or Original referral from hospital or physician indicates health care is required	
3) Social worker/case manager after performing social assessment and coordinating social services, contacts Community Health Nurse for health assessment.	
	4) Community Health Nurse performs health care assessment

5) Community Health Nurse indicates level of health care services required and informs social worker/casemanager

6) Social worker/case manager contacts health care providers to coordinate health care; contacts Community Health Nurse when reassessments are required.

delivery of home care could provide informed comment on their particular areas of expertise.

At the local level, the unit manager will consult with a similar committee. Here it would seem proper for the committee to consist only of representatives of organizations directly involved in providing care in the area served by the unit. In this way, the Committee could become the mechanism whereby agreements concerning the level and type of service to be provided by each organization were reached. These committees could be of manageable size if only homemaking and nursing organizations were represented. The size of this committee could, however, become quite large if there were only six or eight committees and all the voluntary groups providing care in each region were represented on each regional committee. If only one representative of each profession were included on the committee, however, there could be conflicts of interest when, say, a nursing organization represented on the committee was involved in a discussion leading to the determination of which nursing organization should provide care, and how much, in the region.

f) Advantages and Disadvantages

A separate home care agency has the following advantages:

i) The agency is clearly a distinct home care program.

ii) The local units would provide a clearly identifiable single entry point to coordinated home care.

iii) The agency would have its own Minister, capable of promoting home care's interests at the cabinet table.

iv) The agency's budget would not be lost in the budget of a larger department.

On the other hand, a separate agency has the following disadvantages

i) The agency would need to establish its own local units, rather than work through existing homemaker agencies. At least eight local units would be required, at a total cost for staff and equipment alone of $1,000,000.

ii) The central office would have to establish its own financial administration, rather than be able to use the financial services of existing departments. In short, this option has the potential for large and increasing administrative expenditures, expenditures that could be better made on service.

iii) Relations with homemaker agencies are likely to be strained. Since the program's own assessors would be responsible for determining the amount of homemaking to be provided, the homemakers agencies, who currently perform the assessments, could resent this intrusion into their business by Provincial staff.

iv) In this option, nursing and health care are both coordinated by the local home care unit; this is a more cumbersome method than leaving coordination of health care to the Community Health Nurse assessors (as in the other options). To be sure, this model could work in the same way as the others, leaving health assessment and coordination to the Community Health Nurses. Then, however, the local unit becomes little more than an agency for performing assessments for homemaker services, and the homemaker agencies are already performing these assessments satisfactorily.

v) In this Option, advisory groups have an integral role in determining policy and levels of service at both central and local levels. This raises the following questions:

   a) What groups should be represented on the local committees: representatives of all local care providers, or representatives of only one organization in each category of care provider, e.g., VON and Comcare or only VON? Could conflicts of interest be avoided if one organization was chosen to represent a category of care provider on a committee intended to determine levels of service?
   b) Should the local committees, or the local Home Care Unit manager be responsible for hiring employees?
   c) Are formal committees necessary? Could the home care staff not draw on expertise of care providers and recipients informally, as needed?

4. Other Options

The three structures considered above all embody a formal coordinating mechanism staffed to a greater or lesser extent by employees of the Province. These are not, of course, the only structural options, but they are the options which would most directly implement the wishes expressed by informed members of the public in the hearings. There was, in fact, no general consensus concerning the exact form the administrative structure should take, but there was a general consensus that the Province should be responsible for coordination.

Other options fall into two categories

i) those in which the formal coordinating structure is minimal

ii) those in which the Province is not directly responsible for the coordination of home care.

These options will be considered briefly below.

a) Protocols

Whatever system of coordination is adopted, protocols similar to those in Tables 13 and 16 ensuring that homemakers, nurses and other agencies contact each other concerning clients requiring services will be necessary.

A minimal cost option would be to rely upon protocols alone to coordinate home care. A committee of staff from Health and Social Services could develop standardized protocols for use by nursing agencies (whether Community Health or VON) and homemaker agencies throughout the Province. Then, when a client applied or was referred to one of the agencies, the other agencies would, according to the protocols, have to be informed. There would also have to be protocols governing the discharge of patients from hospital.

This method, which is what now happens informally, without protocols, in most parts of the Province, relies upon the diligence of each of the participating agencies to ensure that it works, and that all the agencies whose services a client needs are contacted. The method works reasonably well, but there apparently are clients who slip through the net, and agencies which should have been contacted are not. Hence the concern that a formal coordinating mechanism be introduced. Some years ago, it might have been possible to found a coordinated home care program on protocols, or at least to introduce protocols as a first step, but the demand for a distinct coordinating entity is now so great that a program based only on protocols would probably be perceived as insufficient.

The method has the further drawback that there is no guarantee that the resources of each of the services required will be increased proportionately to ensure that clients can receive the full range of services. Thus the numbers of homemakers in a district might not increase sufficiently for a client who needed both nursing care and homemakers to receive the homemaker portion; and consequently the client might not be able to receive home care, even though home nursing care were available. The reverse situation could also occur.

b) Toll-free Number

Another low-cost option would be the establishment of a toll-free number in Halifax which persons seeking home care anywhere in the Province could dial to receive information concerning in-home services available in their area. This would essentially be an information service, providing the telephone numbers of homemaker, nursing and voluntary agencies to callers.

The information service staff would not actually coordinate care for applicants, merely indicate where providers of care could be located. Most of the callers to this service could be expected to be from the community, since hospital discharge planners and referring physicians would doubtless contact the Community Health Nurses directly.

This service would probably cost $100,000 to $150,000 annually.

On its own, this service would be unlikely to meet the public demand for coordinated home care; it would not be seen as a significant improvement over the existing situation. Combined with formal protocols (as in section (a)), the service might go somewhat further toward coordinating home care, but the criticisms levelled against a purely protocol-based system would continue to apply.

c) Municipal Coordination

In the cities of Halifax and Dartmouth, home care is currently coordinated, at least for persons receiving social assistance, by a municipal agency. The system seems to work well in determining proper levels of service and coordinating care in a cost-effective manner. Indeed, the system's success in the two cities prompted members of the committee presiding over the hearings to ask the public whether a municipally coordinated home care program would be satisfactory on a province-wide basis.

The answer outside of the metropolitan area was resoundingly unfavourable. Most people considered that a municipal program would lead to different levels of service from one municipality to the next, and that the Province could not accordingly benefit from a standardized home care program. In Halifax and Dartmouth it was assumed that the city governments would not only have sufficient resources, but would also be prepared to commit those resources to the home care program. Elsewhere, there were grave doubts whether the municipal governments had sufficient resources or would be prepared to commit sufficient resources to the program to make it effective.

Hence, at least outside Halifax and Dartmouth, the consensus was that Provincial staff should be responsible for coordinating the home care program.

d) Home Care Corporations

Given the importance that many organizations assigned to advisory committees, it is interesting that they did not take the next logical step. This would be to suggest that the home care programs should be locally administered by local home care corporations, similar to elected school boards.

In Saskatchewan, home care at the local level is administered by 45 home care corporations, serving areas whose populations range from 8,000 to 190,000 people. Each corporation consists of people in the community who are interested in providing home care; there is no restriction on membership. The corporation then elects a home care board to coordinate home care in the area. The board makes all decisions concerning staff, the use of public or private, profit or non-profit, agencies for program delivery, the hiring of manpower and the use of program resources.

Overall Provincial policy, procedures, levels of service are established by a central Provincial agency in consultation with the local boards. The Province has defined the core of services each board should offer to be:

- assessment and care coordination
- nursing
- homemaking (including personal care)
- meals on wheels
- handyman/home maintenance (snow shovelling, yard maintenance, minor repairs).

The local boards can decide whether to offer further services. The central agency staff assist and monitor the local boards and maintain a data file on the program.

The Province funds each board by means of a block grant, determined according to the formula:

$44,940 base grant
+$10 per inhabitant of the district
+$44.78 per senior citizen in the district
+$30.00 per senior over 75 in the district

with discretionary funding to districts providing high need and respite care. Each board raises further funding on its own.

In this model, the Province is clearly involved in setting general standards, but local delivery is equally clearly controlled by local inhabitants, not by Provincial staff. Because each local program would depend upon the competence and initiative of the local board, it is hard to assess the general advantages and disadvantages of this system. Perhaps one criticism could be that levels of service could vary from region to region, but to a large degree that criticism is dispelled by considering that each region receives a block grant proportionate to its needs and that a Province-wide core of services is prescribed by law.

A more serious criticism is that this model does not offer the Province any assured means of controlling costs; boards that spent their grant unwisely would demand a higher level of funding, which the Province would find it hard to deny, since the funding would be for health care purposes and the request was

made by a duly elected board. It is of some interest to calculate the cost of home care in Nova Scotia if the Saskatchewan formula were to be applied to a structure composed of 21 regional boards (one for each county, and one each for Halifax, Dartmouth and Sydney):

block grant of $44,940 to 21 boards	= $ 943,740
$10 for each citizen (865,442)	= $ 8,654,000
$44.78 for each senior (100,400)	= $ 4,495,912
$30 for each senior over 75 (39,800)	= $ 1,194,000
	$15,287,652

VII. COST OF A COORDINATED HOME CARE PROGRAM

A. COST OF PROVIDING SERVICE

This chapter considers the costs of providing the various services. Minimum and maximum costs are calculated for each service. In most cases the minimum cost is equivalent to the cost of current services, and the maximum cost is equivalent to the cost of serving a projected client group of 2% of the present population, or 17,300 people. **It should be emphasized that there can be no accurate prediction of the total number of people who actually will require home care in the initial years of the program.** In some areas the program will be meeting a need; in others, it may create a demand that did not exist before. No one at the public hearings, including meetings with care providers, would hazard a guess at how many people in each area would require home care beyond the number of those receiving home nursing and homemaking services now. **Thus the actual initial costs of providing service will probably fall anywhere between the minimum and maximum costs calculated for each service.**

As mentioned above, the Interdepartmental Committee recommends that the home care program initially concentrate on coordinating homemaking, nursing and other existing services, roughly equivalent to items 1,2, 4 (minimum program) and 5 below.

1. Homemaking

At present, the 37 homemaker agencies serve about 3,000 Nova Scotians, of whom some 2,400 are aged 65 or over (80%). The total cost in 1985-86 was $2,837,100, of which the cost to the Province after cost-sharing under the Canada Assistance Plan (CAP) will be about $1,429,898. (See Table 17).

Minimum Cost

The minimum cost of a program serving all Nova Scotians would be the cost of existing homemaker services plus the cost of homemaker services in areas of the Province where these services do not now exist. These areas are:

	Population
- rural Cape Breton County	44,930
- Louisbourg	1,340
- Victoria County	8,640
- Canso	1,250
- Municipality of the District of Shelburne	5,320
1986 Interim Population	61,480

(Lockeport and Port Hawkesbury do not currently have homemaker services but are well on the way to developing them.)

The cost of these additional homemaker services cannot be easily determined, since the budgets of the existing agencies do not correlate uniformly to the number of clients each agency serves. The estimated annual cost of serving a client, according to the Senior Citizens Secretariat, ranged from $459.19 in the Town of Digby (total clients: 57) to $2,220 in the Municipality of St. Mary's (total clients: 47).

Consequently the best way to estimate the cost of additional homemaking at the existing level of service in the areas not yet served is:

i) estimate the per capita cost of service in areas already served by homemakers= cost - population of these areas = $2,837,100 - 803,962 = $3.53

ii) multiply this per capita cost by the population of the areas not yet served = $3.53 x 61,480 = $217,024.

The minimum cost of providing homemaker services to the entire Province, at the current level of service is:

current cost	$2,837,100
plus	
cost of new agencies	217,024
	$3,054,124

Of this sum, about 50%, or $1,538,410, would be the Province's responsibility after cost sharing under CAP.

Since the Province already assumes $1,429,898 of the present costs, the new dollars the Province would have to put into the program would be $1,538,410 - $1,429,898 or $108,512.

Maximum Cost

The maximum cost immediately foreseeable is the cost of providing service to a client group comparable in size to that in other provinces. The increase in size of this client group over the existing client group would be due to greater public awareness of the home care program, generated by publicity during the development phase. **It must be stressed that this is not the maximum cost foreseeable, because the size of the client group is expected to grow, both here and in other provinces.**

Taking the Saskatchewan figures that have been used for comparisons in Table 10, it can be estimated that a maximum of 10,400 people could require homemaking services, at least initially. Consequently, if it now costs $2,837,100 to serve 3,000 clients, by simple proportions, it would take $9,833,390 to serve 10,400 clients. Of this, after 50% cost-sharing under CAP, the Province would be responsible for $4,916,695.

The new money to be found by the Province would accordingly be $4,916,695 - $1,429,898 = $3,486,797.

TABLE 17: DELIVERY COSTS FOR HOMEMAKING

1. Homemaking

Current total number of clients served	3,000
Current number of seniors served	2,400
Total cost (1985-86)	$2,837,100
Cost to Province (after cost-sharing)	$1,429,898

a) Minimum initial cost of new program

Fundamental cost	$2,837,100

plus

New Homemaker Agencies in
- rural Cape Breton Co. (Parts)
- Louisbourg
- Canso
- Shelburne District
- Victoria

in all, about 61,480 people

@ 3.53 per capita population	=	$ 217,024
Minimum cost for serving all Nova Scotians at present level of service.		$3,054,124
Cost to Province, after CAP recoveries		$1,538,410
Extra costs to Province		**$ 108,512**

b) Maximum initial cost of new program

assuming levels of service comparable to other provinces,

If 3,000 clients are now served for	$ 2,837,100
cost to serve 10,400 clients	9,833,390
Cost to Province, after CAP recoveries	$ 4,916,695
Extra costs to Province	**$ 3,486,797**

Recoveries

The public hearings indicated that people were prepared to pay for homemaking and other social services, though they did not feel that there should be a charge for nursing in the home care program.

Currently, 13 of the 37 homemakers agencies charge a nominal fee to persons who qualify for subsidized service. In the case of 10 agencies, the fee is charged on an hourly basis while in the remaining three it is on a per visit basis. The amount of the fee ranges from $2 per visit to $4 per hour.

In designing a fee structure, it is necessary to know the cost of a unit of service - either per visit or hour depending on the unit to be used. Information on costs was obtained from the survey of homemakers agencies conducted by the Senior Citizens Secretariat. Thirty of the agencies responded to the questionnaire. Each indicated the average length of visit and the cost per visit. The data indicate an hourly cost ranging from $3.50 to $28. However, the reliability of the data is questionable because the lowest rate is below minimum wage. Before any fee structure can be designed, more accurate data will be required.

The Interdepartmental Committee initially considered levying a flat hourly charge for all homemaking services provided by the home care program, except for services provided to recipients of social assistance. Such a scheme, however attractive it may seem at first, creates serious problems with cost sharing under the Canada Assistance Plan (CAP). If the Province charged a nominal fee of $2 or $5 per visit or per hour, this is the only sum the Federal Government would cost-share, even though the actual cost of delivering the service could be much greater. Consequently other options must be considered.

Any fee structure developed must take into account the conditions under which costs of homemaking services will be shared by the Federal Government by the terms of the Canada Assistance Plan. Some key points must be borne in mind:

i) The total cost of services provided to persons whose incomes are below the Turning Point, shown in Table 18, are cost sharable under CAP.

ii) Part of the total cost of services provided to the group of persons whose incomes fall between the Turning Point and the Breakeven Point is sharable under CAP.

iii) CAP will not cost share services provided to clients whose incomes exceed the Breakeven Point, except in the case of families at risk, that is, where child abuse is suspected or possible.

iv) Persons receiving the Guaranteed Income Supplement (GIS) are by definition considered to be below the Turning Point. Income testing is required for higher income levels.

There are two principal options for a fee structure. One involves charging full cost of service to clients whose incomes are above the Turning Point. In the other, full costs are charged to clients whose incomes are at or above the Breakeven Point. In the second option, clients with incomes between the two points pay partial cost of service according to a sliding scale.

a) Option A: Full Costs Above the Turning Point

Persons whose income falls below the income levels indicated in the income guidelines (the Turning Point, Table 18) would pay a nominal hourly fee while those above that income level would pay full costs. (An hourly rate has been chosen as it is more frequently used by agencies and it will limit the ability of agencies to skew service delivery to minimize costs to recipients.)

Advantages

i) This option is closer to the current system so it would be easiest to implement.

ii) The administration would be simpler because there is only one income level for each family size.

Disadvantages

i) A slight change in the income of an individual or family could result in substantial increases in their fees.

ii) There will be an inequity among individuals with incomes close to the cutoff point. Those who fall within the guidelines will receive a full subsidy while those outside will pay the full cost; thus a single person with an income of $11,234 p.a. would receive full subsidy, while a single person with an income of $11,236 p.a. would pay full cost.

TABLE 18

MAXIMUM ANNUAL NET FAMILY INCOME SIZE GUIDELINES

1986

Family Size	Turning Point	Breakeven Point
1	11,235	16,853
1 + 1	22,470	33,705
1 + 2	26,215	39,322
1 + 3	29,960	44,940
1 + 4	33,705	50,558
1 + 5	37,450	56,175
1 + 6	41,195	61,793
1 + 7	44,940	67,410
2	22,470	33,705
2 + 1	26,215	39,322
2 + 2	29,960	44,940
2 + 3	33,705	50,558
2 + 4	37,450	56,175
2 + 5	41,195	61,793
2 + 6	44,940	67,410
2 + 7	48,685	73,028

Notes

Turning Point: Below this point client receives full subsidy.

Between Turning Point and Breakeven Point: Client receives partial subsidy.

Breakeven Point: At and above this point client pays full cost of service.

b) Option B: Sliding Scale Between Turning Point and Breakeven Point

A nominal fee for those below a specified income level (Turning Point), a sliding scale for those between the first income level and a second specified level (Breakeven Point), and full fee for those above the second income level.

Table 19 is an example of how such a scale might work based on the 1986 income guidelines approved by the Canada Assistance Plan.

Advantages

i) Small changes in income would result in small increases in costs for individuals.

ii) There would be a more equitable treatment of individuals or couples with incomes that are close to the lower income level (Turning Point).

iii) More persons would be eligible for a subsidy, since persons with incomes between the Turning and Breakeven Points would be partially subsidized.

Disadvantages

i) This option would be more difficult to administer, as may be seen from the fee collection options below.

c) Fee Collection Options

Fees can be collected by the individual agencies or by the central homecare agency.

i) Individual Agencies

If agencies collect, the fee charged should represent the agency cost. If the sliding scale were used, the scale would be designed so that the maximum fee represents the highest cost of service provided. Persons receiving services from an agency with lower costs would pay full costs at lower income levels. For example, using the scale in Table 19, where the agency cost was $14 per hour, single persons with incomes of $14,000 pay full costs.

Advantages

1) Agencies are currently required to collect fees from persons with incomes above those in the guideline and some collect a nominal fee so most will have the necessary administrative mechanism in place.

TABLE 19: POSSIBLE SLIDING SCALE FOR HOMEMAKER FEES

Family of One		Family of Two	
Annual Income	**Fee**	**Annual Income**	**Fee**
$11,500	$4	to $22,500	$4
$11,501 - 12,000	6	22,501 - 23,500	6
12,001 - 12,500	8	23,501 - 24,500	8
12,501 - 13,000	10	24,501 - 25,500	10
13,001 - 13,500	12	25,501 - 26,500	12
13,501 - 14,000	14	26,501 - 27,500	14
14,001 - 14,500	16	27,501 - 28,500	16
14,501 - 15,000	18	28,501 - 29,500	18
15,001 - 15,500	20	29,501 - 30,500	20
15,501 - 16,000	22	30,501 - 31,500	22
16,001 - 16,500	24	31,501 - 32,500	24
16,500+	Full Cost	32,500+	Full Cost

ii) If the agency does the social assessment, it will also be collecting the information needed to determine the fee.

iii) Many people currently pay the homemaker directly and this practice could be continued, minimizing administrative costs.

iv) This system may be more convenient for persons who are house-bound and cannot easily get to a mail box.

v) The full fee would be the actual cost of service.

Disadvantages

i) Some people may feel that this system is too personal.

ii) The fees collected would be seen as property of the agency rather than of the Home Care Program.

iii) Agencies which do not already charge a fee may dislike the prospect of collecting fees.

ii) Central Home Care Agency

If the home care program collects, a fee based on average cost would be easier to administer. The sliding scale would be designed so that the maximum fee represents the average cost of homemaker services provided to clients in the Provincial home care program. If the average cost was $14 per hour, the scale in Table 19 would be changed so that the $14 fee would correspond to $16,500+ for single persons and $32,500+ for couples.

Advantages

i) This system would be more impersonal.

ii) The fees would be part of the Home Care budget rather than the budgets of individual agencies.

iii) More persons would be eligible for a subsidy, since the average cost would be set so that it coincided with the Breakeven Point in the guidelines.

Disadvantages

i) Those agencies which currently collect fees will have to be compensated for the loss of revenue if they are to maintain the current level of service. In other words, funds would have to be provided to make up for the nominal fee they now charge. Since less than 5% of total costs are now recovered in fees, this sum will not be significant.

ii) Administrative costs will be higher.

iii) This system may be less convenient for many. In some cases, homemakers assist with banking and mailing so that the homemaker will be handling the payment anyway.

iv) If an average fee would be used, some people would then pay more than the actual cost of the service they receive.

It should be noted that for recoveries based on an average cost of homemaking services, negotiations with the Federal government would be necessary. No other program in Nova Scotia currently obtains cost-sharing under CAP on the basis of a sliding scale whose upper limit is the average cost of service.

d) General Considerations

More information on costs is required before any decision can be made on the method of billing. With the information currently available, it would appear that collection by the homemakers agencies would minimize administrative costs by using procedures and mechanisms which have been already established in a number of the agencies.

A sliding fee scale is employed in Prince Edward Island, New Brunswick's Community-Based Social Services, Saskatchewan (after an initial 10 units for each of which there is a $3 nominal charge) and in British Colunbia Long Term Care for Seniors and the disabled. No fees are charged in Manitoba and the Northwest Territories because the programs state that fees cost more to collect than they are worth in revenue.

The question of whether fees are actually going to amount to a substantial sum in recoveries must be asked before introducing fees for home care in Nova Scotia. (The decision on whether or not to introduce fees should not, of course, be decided entirely on the basis of significant recoveries; the effect of user fees in preventing abuse of service must also be borne in mind.) It is estimated that 80% of homemaking services in a home care program are directed toward senior citizens. In Nova Scotia, about two-thirds of all senior citizens receive the guaranteed income supplement. Consequently two-thirds of 80%, or 53% of the homemakers client group (including seniors and other age groups) will not have to pay for service. The number may in fact be higher; British Columbia's Long Term Care program for seniors and the disabled states that only 17% of its clients actually contributed toward the cost of care. A similar figure in Nova Scotia would raise the number of clients of all ages in the home care program who did not pay for homemaking services to at least 66%, and even this may be too low. Probably the program planners should contemplate that a maximum of 30% of the program's clients will be able to pay for service, and that a figure of between 10% and 20% may be more probable. (On average, in 1985-86 the homemaker agencies that charged fees recovered 10.0% of their costs from fees.)

It is not realistic to expect significant recoveries from the minimum program, since the minimum program is equivalent to existing homemaker services. The vast majority of the present clients of these services have incomes below the CAP Turning Point and therefore could not be expected to contribute much more than they do now. The Committee has therefore not estimated a figure for recoveries from the Minimum program.

The maximum program, on the other hand, would undoubtedly have more clients who could afford to contribute toward the cost of service received. Assuming 20% recoveries from fees, the recoveries would total $1,966,678. This would leave the Province to pay $3,933,356 after CAP recoveries, or $2,503,458 more than it does now.

e) Homemaker Agencies Serving Families at Risk

Certain homemaker agencies, such as the Children's Aid Society of Halifax and Family Service of Support, specialize in serving families at risk, that is, in cases where child abuse may occur. At present, these agencies do not income test their clients, nor do they charge any fees, since child abuse may occur in all income groups and the homemakers' services should not be denied because a family's income exceeds the CAP guidelines.

The Committee accordingly recommends that there should be no change in these specific agencies' current practice. Other agencies which do not necessarily specialize in serving families at risk may also provide services to a few such families as part of their general caseload. There is no income testing of these families, nor are fees charged. The Committee recommends that this practice should also continue.

As stated above any expenditures on families at risk, in whatever income group, are automatically cost sharable under CAP.

2. Nursing

The actual number of patients served by in-home nursing is not known; nursing statistics for the Department of Health record the total number of visits per year, not the number of persons receiving those visits. (In terms of monitoring the delivery of a home care program, any central agency would be well advised to develop reporting procedures for nursing care and a data bank capable of maintaining statistics on the number of people served, and the number of visits each person received.)

The costs of in-home nursing, however, as provided by Community Health Units and the Victorian Order of Nurses, are known. Table 20, which details these costs, is more or less self-explanatory. Here only a few observations need be made, the chief of these is that these costs assume that **there will be no charge made for nursing care.** This is because, since the

introduction of provincial medical insurance, there has been no charge for health services; indeed, no other home care program in Canada charges for nursing services. The Province will therefore have to assume the cost of home nursing care provided by the VON, which currently charges for care provided in its areas.

It should be stressed that the Province will only pay the VON (or other nursing agencies) for the amount of service prescribed for each client in the home care program by the program's assessor (who would normally be a CHN).

The VON may currently be caring for persons whom the home care assessors might consider ineligible for service from the program. Furthermore, some of the home nursing services could be more suitably performed by CNAs or the VON's new Home Care Aides. In fact, the Department of Health estimates that some 60% of home nursing can be delivered by CNAs rather than by Registered Nurses. This could result in substantial savings, since a visit from a CNA or a Home Care Aide costs less than a visit from an RN. Consequently, the program might not have to pay the full $1,620,000 the VON currently spends on in-home service (in addition to the $285,000 Provincial grant and $28,792 fee for service in West Pictou). In any case, the program might negotiate an hourly fee structure (similar to that in West Pictou) with the VON which would result in a cost to the Province of less than $1,620,000. Indeed, if the experience of home care programs in other provinces is illustrative, negotiation of such a fee structure would be an essential element in controlling the costs of the home care program. In calculating the minimum costs for home care nursing, however, the Committee decided to use $1,620,000 as the base figure for expenditures on nursing care currently performed by the VON.

Minimum Cost

The minimum initial cost of the nursing portion of the home care program would be the same as current costs of in-home nursing provided by the Community Health Nurses, Martha Home Health and the VON. The figure is $3,208,600. The Province would have to find $1,620,000 in new funds.

Maximum Cost

Neither the total number of clients requiring home nursing care nor the total number of visits they would require can be readily determined. Consequently, calculation of the maximum costs of home nursing must be approached from a different angle, namely, by determining the maximum expenditure in salaries for nurses providing in-home service. The Extra Mural Hospital of New Brunswick indicated that, ideally, a home care program would require one nurse for every 3,900 people in the general population. Extra Mural Hospital does not itself employ as many nurses as would be required by this ratio, and therefore this may be taken as a counsel of perfection, showing the maximum number of nurses required.

As Table 20 shows, the program would require 222 nurses at $30,000 average salary per annum, giving a total of $6,660,000. The Province would thus have to find $5,071,400 in new funds.

The Department of Health estimates that 60% of home nursing services can be performed by CNAs. At an annual salary of $19,700, the maximum costs of a program employing CNAs for 60% of the services would be $5,290,100. The extra costs to the Province would be $3,701,500.

These figures do not include travel, administration, supplies or benefits.

Recoveries

The possibility of charging for in-home nursing services, as the VON does now, was considered by the Committee, and rejected. The reasons are:

i) the home care program would be the only one in Canada that charged for health care services

ii) there was a solid consensus at the public hearings against charging for health care

iii) charges for home nursing would impede easy discharge of patients from hospitals to the home care program. A patient would be unlikely to wish to be discharged from hospital, where service is free, to a home care program where there was a charge for nursing care.

3. Physiotherapy

Minimum Cost

The minimum cost of providing home physiotherapy services would be equivalent to the present annual grant to the Arthritis Society, or $225,000.

Maximum Cost

The Arthritis Society estimates that full coverage of the Province would require an expenditure of $700,000 annually. Assuming that the Society's ability to raise funds privately remained more or less constant, this would mean an increase in the size of the Provincial grant to, say, $650,000 annually. This would involve $425,000 in increased expenditures.

TABLE 20: DELIVERY COSTS FOR NURSING CARE

2. Nursing Care

Current Costs	
Community Health Nursing	$1,240,100
Special Projects (VON Pictou and Martha Home Health)	63,500
Discretionary Grant (VON)	285,000
	$1,588,600

a) Minimum initial cost of new program

Assume that program coordinates existing home health care only;
Assume that health services are free of charge to clients;
Assume therefore that the new program assumes VON's costs;
Consequently, home health care costs are

Current Departmental Costs	$1,588,600
plus VON Budget	1,620,000
	$3,208,600
Extra costs to Province	**$1,620,000**

b) Maximum initial costs (excluding travel, supplies and administration)

Extra Mural Hospital of New Brunswick indicates that a yardstick to determine number of nurses necessary in a home care program is one nurse per 3,900 population.

For a population of 865,442 in Nova Scotia, therefore, 222 nurses would be required.

Average wage for an RN is $30,000 p.a. (excluding benefits)

Therefore maximum initial costs would be	$6,660,000
Extra costs to Province	**$5,071,400**

On the assumption that 60% of the staff would be CNAs @ $19,700 p.a. (excluding benefits) maximum Initial costs would be	$5,290,100
Extra costs to Province	**$3,701,500**

4. Occupational Therapy

Minimum Cost

At present, the three Eastern Shore hospitals - Eastern Shore Memorial, Musquodoboit Valley Memorial and Twin Oaks Memorial - sponsor the provision of home services by an occupational therapist, at the cost of $9,000 per annum.

Maximum Cost

The Nova Scotia Society of Occupational Therapists advises that, ideally, there should be one occupational therapist for every 20,000 people in rural Nova Scotia. On the other hand, the Society states that one therapist to serve each home care region would probably be sufficient. Assuming seven regions and an average salary for an occupational therapist of $28,000, this would entail an expenditure of $196,000 by the Province ($187,000 in new money). This figure does not include the cost of benefits, travel, administration and supplies.

5. Hospital Participation in Home Care Program

Minimum Cost

At present, hospitals around the Province offer a range of home health services. The total cost is $791,736.

Maximum Cost

Staff of the Health Care Institutions Division of Health indicated that hospitals around the Province could be encouraged to provide more services to patients at home. As an example, one percent of each community hospital's budget could be designated a non-portable item to be spent on home care. Similarly, one percent of that portion of each regional hospital's budget considered to be spent serving the immediate catchment area would be so designated. A prorating formula would have to be found for Halifax hospitals. Initial calculations suggest that by this means about $2,426,000 could be added to the home care budget (including about $931,000 from the Halifax hospitals). This would, of course, be drawn from the existing budget, and no new Provincial expenditures would be required.

The nature of the services would depend upon local demand and the services each hospital would be able to provide. For the system to work effectively, a good relationship would have to be established between the local hospitals and the local assessment teams of the home care program. There should be no question of the home care program demanding services peremptorily from the hospitals: development of service should occur in an atmosphere of trust and understanding.

TABLE 21: DELIVERY COSTS FOR PHYSIOTHERAPY, OCCUPATIONAL THERAPY AND HOSPITAL HOME HEALTH SERVICES

3. Physiotherapy

a) minimum cost (existing services)

Arthritis Society's current budget	$ 265,000
of which, Province grants	225,000

b) maximum cost (full coverage)

Society estimates that full coverage would cost	$ 700,000
Presumable Provincial grant required:	650,000
Extra costs to Province	**$ 425,000**

4. Occupational Therapy (excluding travel, benefits, administration and supplies)

a) Minimum cost (existing services)

Home services from Eastern Shore Memorial/ Musquodoboit Valley Memorial/Twin Oaks Memorial	$ 9,000

b) Maximum cost

Society of Occupational Therapists advises that there are probably enough occupational therapists in Halifax/Dartmouth, but there should be 1 for every 20,000 people in other areas, i.e. 34.5 positions serving some 690,000 people.

At $28,000 average salary, cost =	$ 966,000
Society states one therapist per region (say 7) would be sufficient =	$ 196,000
Extra costs to Province, at least	**$ 187,000**

5. Hospital home health services

Current costs	
Home oxygen	$ 125,000
Home renal dialysis	461,200
Elemental food	38,000
Staff home visits	61,000
Other	106,536
	$ 791,736

6. Conclusions

The estimated total delivery costs for the initial stages of a home care program with a core of homemaking and nursing services are shown in Table 22.

The important figures to note in relation to a program serving all Nova Scotians are:

current costs	$3,018,500
minimum extra costs (initially)	1,728,500
maximum extra costs (initially)	8,558,200

The actual extra costs are impossible to predict within the limits noted, because the exact size of the client group cannot be predicted. In all likelihood, however, the initial costs will be somewhat higher than the minimum figure, but not as high as the maximum.

With 20% recoveries from fees for the homemaking portion of the program, these figures become

minimum extra costs (initially)	$1,728,500
maximum extra costs (initially)	7,860,800

TABLE 22: TOTAL INITIAL DELIVERY COSTS FOR PROGRAMS PROVIDING A CORE OF NURSING AND HOMEMAKING SERVICES

Current costs to Province

Homemaking (after CAP recoveries)	$1,429,900
Nursing	1,588,600
Total	$3,018,500

a) Minimum Costs for total coverage (services only)

Homemaking	$3,054,100
Nursing (free of charge)	3,208,600
	$6,262,700
less recoveries from CAP	-1,515,700
Total	$4,747,000
Extra Costs to province	**$1,728,500**

b) Maximum costs for total coverage (services only)

Homemaking	$9,833,400
Nursing (free of charge)	6,660,000
	16,493,400
less recoveries from CAP	4,916,700
Total	$11,576,700
Extra costs to Province	**8,443,200**

B. Initial Administration Costs (Salaries and Office Expenses)

The administration costs of some of the structural options are schematized in Table 23.

The lowest cost option is, of course, the establishment of protocols for cross referral by existing agencies. These protocols could be developed by existing staff in the Departments of Health and Social Services and in the agencies concerned.

A toll-free telephone information service would cost between $100,000 and $150,000.

Section 3 of Table 23 shows the fundamental staff required to develop any of the three major options. This staff consists of a Provincial Coordinator/Executive Director, an Assistant Coordinator/ Director, the Director of Homemaker Services and his secretary, seven Field Representatives and clerical staff. Expenditures on salaries would amount to $508,000 and on office expenses to $210,000 in the first year. (Many of the office expenses in this year are on the purchase of durable items.) This gives a base cost of $718,000. ($650,000 in new funding) for the administration of the program.

Section 4 shows the additional expenses required if a billing agency were required. If the program could not use one of the existing computers in a government department, it would have to buy its own. A microcomputer would be too small for the program's purposes, and therefore a minicomputer, equivalent to an IBM system 36 or a Digital VAX, would be needed to process the bills and perform statistical operations. The full extra cost of a billing agency would be about $117,000.

Section 5 shows the additional costs for Option 1, a Home Care Coordinating Agency with its administration located in Social Services. The basic staff requirements are the same as in Section 3, and the Division would presumably be able to use the Department of Social Services' computing capacity. Hence the cost in salaries and office expenses, including a billing agency, would be $798,000, or $730,000 in new funds.

Option 2, Joint Coordination by Health and Social Services, costs much the same as Option 1 (see Section 6). A Home Care Coordinator in the Community Health Division (assuming the workload became too great for the Director of Nursing) would add somewhat to the cost. The total would then be $843,000, or $775,000 in new funding.

Option 3, the Separate Home Care Agency, is considered in Section 7. Since this option involves local units, and the local unit managers will be instrumental in creating local contacts, which is the role of the Field Representatives in the other two major options, the costs for Field Representatives are eliminated from the central agency expenses here. The central agency, including a full billing agency, would cost $538,000. Costs for each local unit would be about $124,000. Consequently, for 8

units, the administration costs for this Option are much higher than in the previous two: $1,530,000 (or $1,462,000 in new funding).

TABLE 23: ADMINISTRATION COSTS BY OPTION
(excluding accommodation)

1.	**Protocols for cross referral by existing agencies**	- no extra cost
2.	**Toll-free number in Halifax to refer applicants to existing services**	
	- supervisor	$32,000
	- 2 information staffers	56,000
	- telephone bills	30,000
	- supplies	2,000
	- miscellaneous	4,000
		$124,000
	(based on 170-200 calls p.d.)	
3.	**Fundamental staff component required to develop program coordination**	
	Salaries	
	Provincial Coordinator/Executive Director	$ 65,000
	Assistant Coordinator/Director	45,000
	7 Field Representatives @ $35,0000 ea.	245,000
	Statistical Clerk	30,000
	2 Clerical	55,000
	Director (Homemaker Services) and secretary	68,000
		$508,000
	Office Expenses	
	Travel	60,000
	Stationery and Printing	25,000
	Miscellaneous	2,500
	Postage (excluding special mailings)	23,000
	Telecommunications	20,000
	Equipment Repairs and Maintenance	1,500
	Travel and Messenger	750
	Equipment (copier lease, word processor/ computer, typewriter, dictating equipment)	25,000
	Furniture - office	22,000
	- boardroom	10,000
	Staff Training and Development	1,000
	Meeting Expenses	10,000
	Membership Dues and Fees	500
	Periodicals and Books	2,000
	Other	6,750
		$210,000
	Total, Salaries and Office Expenses	$718,000
	Extra cost to Province	**650,000**

4. Billing Agency: Basic components

Salaries	
Accounting Supervisor	$ 35,000
Accounting Clerk	25,000
	$ 60,000
Office Expenses	
Minicomputer	30,000
Software	7,000
Stationery	3,000
Postage for billing	15,000
Furniture	2,000
	$ 57,000
Total	$117,000
Extra cost to Province	**$117,000**

5. Option 1: Home Care Coordinating Agency

Salaries and office expenses as in (3) above	$718,000
Billing system would make use of Social Services computer and software. Consequently, costs are as (4), modified	
Salaries	$ 60,000
Office Expenses	20,000
	$ 80,000
Total	$798,000
Extra Cost to Province	**$730,000**

6. Option 2: Joint coordination by Health and Social Services

Social Services	
Costs are the same as in Option 1	$798,000
Health	
Home Care Coordinator (if work could not be done by Director of Nursing)	45,000
Total	$843,000
Extra Cost to Province	**$775,000**

7. Option 3: Separate Home Care Agency

a) Central Agency

Salaries	
same as in (3), excluding the 7 Field Representatives	$508,000 -245,000 $263,000
Office Expenses	
same as in (3), excluding those associated with Field Representatives (Travel, Furniture and Dictating Equipment)	$210,000 -52,000 $158,000
Total, salaries and office expenses	$421,000
Full Billing Agency, as in (4)	$117,000
Total	$538,000

b) Local Unit Administration

Salaries	
Manager	$ 35,000
Case Manager	32,000
Clerical	22,000
	$ 89,000
Office Expenses	
Travel	$ 8,000
Stationery and Printing	4,000
Miscellaneous	1,500
Postage	800
Telephone	5,000
Equipment repairs	500
Furniture and equipment (typewriter, copier)	10,000
Staff training	300
Membership Dues and Fees	150
Periodicals and Books	500
Other	4,250
	$ 35,000
Total cost per unit (excluding meeting costs for advisory committees)	$124,000
Assuming the existence of 8 units	$992,000

c) Total costs of separate agency

central agency	$538,000
8 local units	$992,000
Total	$1,530,000
Extra cost to Province	**$1,462,000**

C. TOTAL INITIAL COSTS OF ADMINISTRATION AND DELIVERY: THE THREE MAJOR OPTIONS

Tables 24 and 25 show the total initial costs of administration and delivery for the three major options, calculated for the supposed minimum and maximum initial costs of delivery. Table 24 shows the costs without a charge for homemaking services; Table 25 includes this charge. **It must be clearly understood that these costs do not include costs of accommodation for the central agency and field representatives in options 1 and 2 nor of the central agency and local units in option 3.** These costs are dependent upon whether the program could be housed in government-owned buildings or had to rent space.

The total costs also exclude the $800,000 currently spent on hospital-based services to patients at home, since these costs are currently included in the hospital budgets.

The table shows there is little difference in initial costs between options 1 and 2, namely, between coordination by a Home Care Coordinating Agency with its administration located in the Department of Social Services and joint coordination by the Departments of Health and Social Services. In round figures, the minimum extra cost to government, after charging for homemaking, is $2,000,000, the maximum is $8,000,000. (Recoveries from homemaking have been estimated at only 20% of costs, so as not to exaggerate the possibilities of recovering costs through fees.)

The minimum and maximum initial costs of option 3, a separate Home Care Agency, are about one million dollars more than the other two options: $3,000,000 to $9,000,000.

Concerning these figures, three points should be made:

i) **During the initial year to 18 months while the coordinating agency is still developing the patterns of coordination, the extra costs to government will be administrative only: about $700,000 or $800,000 p.a. for options 1 and 2, and anywhere from $800,000 to $1,500,000 p.a. for option 3.**

ii) **The minimum and maximum figures are those for the initial year of operation, that is, after the patterns of coordination have been developed and coordinated delivery has started. The exact number of clients cannot be foretold with any accuracy, but it is probable that the actual extra costs will be somewhere between the minimum and maximum regardless of the option chosen.**

iii) **Once the program is in operation, costs can increase very rapidly. In 1985-86, the Provincial contribution to Saskatchewan's home care program was $19,900,000. The year it will be $23,000,000. Of the three options, the separate home care agency shows the most potential for rapid increase in administrative costs.**

There is yet another major consideration. The total costs calculated in the Tables refer to the costs to the Province. Currently, however, the costs of providing homemaking service are not borne by the Province alone, although Provincial funding (before CAP cost-sharing) accounts for about 76% of the total costs of homemaking services in Nova Scotia. The remainder is found by the agencies themselves, from municipal grants, fees and fund-raising. Municipal grants constitute a significant portion of many agencies' budgets. If the agencies are required to expand their services as a result of the home care program, there would be pressure on the municipalities to increase the dollar amount of their grants. Many municipalities have indicated that they are hard-pressed financially, and would have difficulty in increasing these grants. There might well then be pressure upon the Province to increase its contribution to the home care program.

TABLE 24: TOTAL INITIAL COSTS OF THE THREE MAJOR OPTIONS

(Excluding Billing)

	Service (after CAP)	Administration (excluding billing)	Total	Extra Cost to Province
Option 1: Home Care Coordinating Agency				
minimum	$ 4,747,000	718,000	5,456,000	2,378,500
maximum	11,576,700	718,000	12,294,700	9,208,200
Option 2: Joint Coordination by Health and Social Services				
minimum	4,747,000	718,000	5,465,000	2,378,500
maximum (inc. Home Care Coordinator in Health)	11,576,700	763,000	12,339,700	9,253,200
Option 3: Separate Home Care Agency				
minimum	4,747,000	1,413,000	6,160,000	3,073,500
maximum	11,576,700	1,413,000	12,989,700	9,903,200

TABLE 25: TOTAL INITIAL COSTS OF THE THREE MAJOR OPTIONS

(with billing for homemaking)

	Homemaking	20% Recoveries from fees	Cost of Homemaking (after fees)	(after CAP)	Nursing	Total Service	Admin.	Grand Total	Extra Cost to Province
Option 1: Home Care Coordinating Agency									
minimum	3,054,100	-	3,054,100	1,538,400	3,208,600	4,747,000	798,000	5,545,000	2,458,500
maximum	9,833,400	1,966,700	7,866,700	3,933,400	6,660,000	10,593,400	798,000	11,391,350	8,304,900
Option 2: Joint Coordination by Health and Social Services									
minimum	3,054,100	-	3,054,100	1,538,400	3,208,600	4,747,000	798,000	5,545,000	2,458,500
maximum	9,833,400	1,966,700	7,866,700	3,933,400	6,660,000	10,593,400	843,000	11,436,400	8,349,900
Option 3: Separate Home Care Agency									
minimum	3,054,100	-	3,054,100	1,538,400	3,208,600	4,747,700	1,530,000	6,277,000	3,190,500
maximum	9,833,400	1,966,700	7,866,700	3,933,400	6,660,000	10,593,400	1,530,000	12,123,400	9,036,900

VIII. RECOMMENDATIONS

1. A coordinated home care program should be introduced in Nova Scotia. The central coordinating agency should be a new Home Care Coordinating Agency, directed by a Committee of Ministers, with its administration located in the Department of Social Services. The local coordinating agencies should be designated homemaker agencies and in Halifax and Dartmouth the existing home care coordination offices. Assessment and case management should be performed by a team consisting of a Community Health Nurse and a homemaker.

Central Coordination

2. The Home Care Coordinating Agency should be given policy and administrative direction by a committee comprising the Ministers of Health, Housing, Municipal Affairs and Social Services, under the chairmanship of the Minister of Social Services.

3. Implementation of the decisions of the Ministers' Committee should be the responsibility of a Deputy Ministers' Committee on coordinated Home Care. This committee should comprise the Deputy Ministers of Health, Housing, Municipal Affairs and Social Services, and the Provincial Coordinator of Home Care (see Recommendation 5).

4. A Home Care Advisory Committee should be established to provide informed comment on home care issues to the Deputy Ministers' Committee. The Advisory Committee should include representatives of professional organizations; homemaker agencies; volunteer groups, such as the Royal Canadian Legion and church groups; groups representing clients of home care, such as the disabled and senior citizens; and other organizations providing home care or involved in home care. The Advisory Committee should be appointed by the Deputy Ministers' Committee, after consultation with the Ministers' Committee.

5. A Provincial Coordinator of Home Care, of Executive Director rank, should be appointed to head the Home Care Coordinating Agency's administration, located in the Department of Social Services.

6. An Assistant Coordinator, seven Field Representatives, a Statistical Clerk and clerical support should be appointed as staff to the Provincial Coordinator.

7. The Director of Homemaker Services and his secretary and associated budget should be transferred from the Family and Children's Services Division in the Department of Social Services to the new Home Care Agency administration.

8. If necessary, an Accounting Supervisor and an Accounting Clerk should be appointed to the Home Care Agency administration to develop and operate a billing system for the program.

9. The first responsibility of the Provincial Coordinator and staff should be to coordinate existing home care services in Nova Scotia.

10. At least one year should be allowed to enable the Ministers' and Deputy Ministers' Committees of the Home Care Agency, and the Provincial Coordinator and staff to make the necessary arrangements with organizations of care providers to deliver home care services as part of the coordinated home care program.

11. The Provincial Coordinator should ensure that policy guidelines, standards of care, protocols to ensure cooperation between care givers and reporting procedures are developed by the Home Care Agency.

12. The Deputy Ministers' Committee should arrange with the Department of Health to ensure the participation of Community Health Nurses as assessors and care providers in the program. The Provincial Coordinator of Home Care and the Director of Community Health Nursing should cooperate in establishing the staffing arrangements at the local level.

13. The Deputy Ministers' Committee, in association with the Community Health Division of the Department of Health, should negotiate with the Victorian Order of Nurses and other nursing agencies to determine the levels of service they are prepared to provide to the program and the appropriate rates of remuneration.

14. The Deputy Ministers' Committee should negotiate with the municipalities to ensure their cooperation and their support of the program. The Cities of Halifax and Dartmouth should be approached so as to arrange that their current home care coordination agencies continue as the local centres for assessment and coordination in each city. The Provincial Coordinator should then cooperate with municipal home care officials to ensure common procedures and standards of service.

15. With direction from the Ministers' and Deputy Ministers' Committees, the Provincial Coordinator and the Director of Homemaker Services should negotiate with the homemaker agencies to ensure their participation in the program as assessors and local coordinators as well as providers of homemaking services.

16. With direction from the Ministers' and Deputy Ministers' Committees, the Provincial Coordinator and the Director of Homemaker Services should negotiate with homemaker agencies specializing in services to families at risk to determine

the nature of their involvement with the coordinated home care program.

17. With direction from the Ministers' and Deputy Ministers' Committee, the Provincial Coordinator should negotiate with Provincial volunteer agencies to ensure their participation in the provision of home care services. Day to day cooperation should occur through the Provincial Coordinator and home care staff, who should encourage the participation of volunteer organizations in the program, and promote the development of volunteer organizations in areas where they do not now exist.

18. During the development stage of the coordinated home care program, the Field Representatives should supervise the implementation of agreements between the Home Care Agency and care providers in their areas. They should also promote the development of homemaker and volunteer agencies in areas where these do not now exist. After the program is in operation they should be responsible for promoting harmonious relationships between delivery agencies and for monitoring the effectiveness of the program at the local level. They should explain the program to care providers (especially to physicians, to encourage them to refer patients to the program) and to the general public.

19. The Assistant Coordinator and Statistical Clerk should develop a database on home care clients and develop indicators necessary to monitor and evaluate the program.

Local Coordination

20. The local coordinating agencies should be chosen from the existing homemaker agencies and, in the cities of Halifax and Dartmouth, the existing home care coordination agencies. Where more than one homemaker agency exists in a given area, the Provincial Coordinator and Field Representatives should ensure that agreements are reached concerning each agency's service area and quantity of service.

21. With the assistance of the Field Representatives, the homemaker agencies, as the local coordinating agencies, should be responsible for maintaining contact with volunteer agencies and other providers of social-service-type home care. They should also maintain close contact with the local Community Health Nurse.

22. Each homemaker agency that is a local coordinator should maintain a toll-free telephone number as the principal point of entry for applicants for home care.

Assessment and Case Management

23. The Provincial Coordinator and staff should formulate appropriate criteria for eligibility for the coordinated home care program. They should also develop assessment forms that enable assessors to determine whether a client meets the criteria.

24. Among the criteria for eligibility should be:

    a) cost of providing home care does not exceed cost of similar services in an institution

    b) family members, if able, indicate their willingness to help home care staff care for the client.

25. Assessment of applicants for home care should determine whether they require health services or social services (including homemaking) or a combination of both. The delivery of these services should then be coordinated for eligible clients.

26. Assessment of applicants for home care should be undertaken by a team consisting of a homemaker from the coordinating homemaker agency and the local Community Health Nurse. The homemaker should perform assessments for homemaking and other social services, the Community Health Nurse should perform assessments for health services. The two assessors do not have to visit every client together, but they should be in close contact and indicate to each other when a client who has been assessed for social services requires a health assessment, and vice-versa.

27. Once a client has been assessed, and the assessors have compared notes (where necessary), a care plan should be drawn up for the client. After the plan has received the client's assent, the homemaker assessor should coordinate homemaking and other social services for the client, while the Community Health Nurse should coordinate health services.

28. In coordinating care for the client, the assessors/case managers should prescribe the minimum level of service compatible with the client's health and well-being, so as to preserve the client's personal independence as much as possible.

Services

29. In developing home care beyond the existing services, the chief areas of concentration should be homemaking, home nursing and volunteer services.

30. Homemaker services should be expanded to cover the municipalities where they do not now exist (or are not already being developed).

31. The Home Care Division should examine the need for further home care services and, if the need for them becomes apparent, add them to the coordinated program as resources become available.

32. The Home Care Coordinating Agency should evaluate the results and effectiveness of the HIL Home Support Program which provides attendant care to the disabled with a view to consider the inclusion of attendant care in the coordinated home care program.

33. Initially, home nursing services should be provided by Community Health Nurses and the Victorian Order of Nurses in their respective areas. The Home Care Coordinating Agency should, however, evaluate the effectiveness of these services and consider employing other nursing agencies where warranted.

34. Existing home care services provided by hospitals should be coordinated in the early stages of the coordinated home care program. Certain hospital-based services should gradually be added to the program as demand indicates and resources become available.

Payment for Service

35. The Department of Health should mandate health assessment and case coordination as regular duties of the Community Health Nurses. Cost of providing these services should be assumed by the Department of Health.

36. The Home Care Coordinating Agency administration, located in the Department of Social Services, should be responsible for paying the Department of Health, through an interdepartmental chargeback, for home nursing delivered by Community Health Nurses.

37. The Home Care Coordinating Agency administration should be responsible for paying the Victorian Order of Nurses and other nursing agencies for the delivery of home nursing services to the coordinated home care program. These services should be provided at rate of remuneration negotiated with the agencies by the Deputy Ministers' Committee, in association with the Community Health Division of the Department of Health.

38. Clients of the coordinated home care program should receive home nursing free of charge.

39. The Home Care Coordinating Agency administration, located in the Department of Social Services, should continue to fund approved homemaker agencies at the current levels of cost-sharing.

40. Families at risk and clients in receipt of Social Assistance or the Guaranteed Income Supplement should receive homemaking services free of charge.

41. For other clients, there should be a charge for homemaking services dependent upon family size and income.

42. A study of costs should be undertaken before any decision is made on the method of billing for service, whether by the Home Care Coordinating Agency administration or by the individual homemaker agencies.

APPENDICES TO THE REPORT OF THE DEPUTY MINISTERS OF HEALTH, HOUSING AND SOCIAL SERVICES ON COORDINATED HOME CARE

APPENDIX 1: HOME CARE SERVICES CURRENTLY PROVIDED BY THE DEPARTMENT OF HEALTH, VICTORIAN ORDER OF NURSES AND ARTHRITIS SOCIETY

Inverness County

Community Health Nursing
- Cheticamp (in hospital) - one CHN
- Inverness (in hospital) - one CHN
- Margaree Forks - one CHN
- Port Hawkesbury - two CHNs, one CNA
- Port Hood - one CHN

Hospital Home Care
- Inverness (Consolidated) - Home Oxygen Program has one concentrator

Psychiatric Home Visits
- 24 home visits made in 1985

Victoria County

Community Health Nursing
- Baddeck - one CHN, one CNA
- Neil's Harbour (in hospital) - one CHN

Hospital Home Care
- Baddeck (Victoria County) - Home Oxygen Program has one concentrator; collection of lab specimens from home for aged

Home Physiotherapy Program
- Victoria County - one full time physiotherapist

Psychiatric Home Visits
- 2 home visits made in 1985

Richmond County

Community Health Nursing
- Arichat - two CHNs
- St. Peter's - one CHN

Psychiatric Home Visits
- 79 home visits made in 1985

Cape Breton County

Community Health Nursing
- Glace Bay - four CHNs, one CNA
- New Waterford (in hospital) - two CHNs
- Sydney - one Supervisor, one Assistant Supervisor, seven CHNs, one CNA
- Sydney Mines - five CHNs, one CNA

Hospital Home Care
- New Waterford (New Waterford Consolidated) - occasional loan or use of home oxygen equipment; home renal dialysis provided for one patient
- North Sydney (Northside/Harbourview) provides transportation of patient to and from day care
- Glace Bay (Glace Bay Committee) - two respirators in Home Oxygen Program
- Sydney (St. Rita) - one concentrator in Home Oxygen Program; some provision of elemental food; meals provided for Meals on Wheels Program at cost; occasional home visit by social worker
- Sydney (Sydney City) - one respirator occasionally loaned in Home Oxygen Program; two patients provided elemental food; occasional home visit by social worker

VON
- Cape Breton Metro Area Branch - seven full-time nurses

Home Physiotherapy Program
- Glace Bay - one part-time physiotherapist (half-time)
- Sydney - one part-time physiotherapist (Fifteen hours per week)

Psychiatric Home Visits
- 129 home visits made in 1985

Antigonish County

Community Health Nursing
- Antigonish - four CHNs, one CNA
- Antigonish County - St. Martha's Home Care Pilot Project

Hospital Home Care
- Antigonish (St. Martha's) - one concentrator and one respirator in Home Oxygen Program

Psychiatric Home Visits
- 62 home visits made in 1985

Guysborough County

Community Health Nursing
- Isaac's Harbour - one CHN
- Mulgrave - one CHN
- Sherbrooke - one CHN, one half-time CNA for home care only
- Guysborough - one CHN, one CNA, two half-time CNAs for home care only
- Canso - (in hospital) - one CHN

Psychiatric Home Visits
- 250 home visits made in 1985

Pictou County

Community Health Nursing
- New Glasgow - four CHNs, one CNA (two of CHNs in hospital)
- Pictou - one Supervisor, two CHNs
- Westville - one CHN
- West Pictou County - Home Care Pilot Project with VON

Hospital Home Care
- Pictou (Sutherland Harris) - one concentrator and three ventilators in Home Oxygen Program
- New Glasgow (Aberdeen) - four concentrators in Home Oxygen Program

VON
- New Glasgow Branch - two full-time nurses
- Pictou Town District Branch - one full-time nurse

Psychiatric Home Visits
- 211 home visits made in 1985

Cumberland County

Community Health Nursing
- Amherst (in hospital) - four CHNs, one CNA
- Parrsboro (in hospital) - one CHN
- Pugwash - one CHN
- Springhill (in hospital) - two CHNs, one half-time CNA for home care only

Hospital Home Care
- Amherst (Highland View) - one respirator in Home Oxygen Program; provides meals for Meals on Wheels Program at cost; occasional home collection of lab specimens; transportation of psychiatric patients to day hospital
- Parrsboro (South Cumberland) - occasional home visits for occupational therapy; occasional collection of lab specimens from home; the hospital has a full-time coordinator for a pilot outreach program for Parrsboro and area
- Pugwash (North Cumberland) - occasional collection of lab specimens from home
- Springhill (All Saint's) - provides supplies only for home renal dialysis program
- Advocate Harbour (Bayview Memorial) - occasional home visit by nurse to support cancer patients; periodic specimen collection

VON
- Amherst Branch - two full-time nurses

Psychiatric Home Visits
- 250 home visits made in 1985

Colchester County

Community Health Nursing
- Stewiacke - one CHN, one CNA
- Truro - one Supervisor, seven CHNs, one CNA (two of CHNs in hospital)
- Tatamagouche - one CHN

Hospital Home Care
- Truro (Colchester) - two respirators in Home Oxygen Program

VON
Truro Branch - two full-time nurses, one part-time nurse

Home Physiotherapy Program
- Colchester County - one part-time physiotherapist (three days per week)

Psychiatric Home Visits
- 119 home visits made in 1985

Halifax County

Community Health Nursing
- Bedford, one Supervisor, one Assistant Supervisor, eight CHNs, two CNAs
- Dartmouth - one Assistant Supervisor, sixteen CHNs, four CNAs
- Halifax - one Assistant Supervisor, twelve CHNs, three CNAs, two liaison nurses (IWK and Grace)
- Spryfield - one Assistant Supervisor, nine CHNs, three CNAs
- Hubbards - one CHN
- Middle Musquodoboit (in hospital) - one CHN, one CNA
- Musquodoboit Harbour - two CHNs, one CNA
- Sheet Harbour - one CHN

Hospital Home Care
- Sheet Harbour (Eastern Shore Memorial) - some occupational therapy home visits in conjunction with TOM and MVM; occasional provision of bed and laundry service for home patient
- Middle Musquodoboit (Musquodoboit Valley Memorial) - some occupational therapy home visits in conjunction with TOM and ESM: occasional home visits by physiotherapists

- Musquodoboit Harbour (Twin Oaks Memorial) - occasional occupational therapy home visits in conjunction with ESM and MVM; support at Birches Nursing Home by Dietician and occupational therapist; lab specimens collected from home for aged on occasion
- Halifax (Camp Hill) - home assessment by occupational therapist and geriatrician
  (Halifax Infirmary) - provision of elemental food to three patients; some palliative care provided
  (IWK) - twelve concentrators in Home Oxygen Program, Cystic Fibrosis Nutrition Program; tube feeding oncology/hematology patients; apnea monitors; tube feeding of renal patients; home immunoglobin replacement therapy
  (Victoria General) - eleven concentrators in Home Oxygen Program; Home Renal Dialysis Program; some provision of elemental food
  (Nova Scotia Rehabilitation Center) - occasional loan of physiotherapy or occupational equipment
  (Nova Scotia Hearing and Speech) - some home visits to stroke patients; home care for multiple handicapped persons

VON
- Halifax Breanch - eighteen full-time nurses
- Dartmouth Branch - four full-time nurses

Home Physiotherapy Program
- Dartmouth - one full-time physiotherapist
- Halifax - two part-time physiotherapists (total five days per week)
- Bedford/Sackville - one part-time physiotherapist (two days per week)

Psychiatric Home Visits
- 813 home visits made in 1985

Lunenburg County

Community Health Nursing
- Bridgewater - one Supervisor, three CHNs, two CNAs
- Chester - two CHNs
- Lunenburg - one CHN, one half-time CNA for home care only
- New Germany - one CHN

Hospital Home Care
- Bridgewater (South Shore Regional) - six concentrators in Home Oxygen Program; occasional home visit by social worker
- Lunenburg (Fisherman's Memorial) - one concentrator in home oxygen program; occasional loan of physiotherapy equipment

Home Physiotherapy Program
- Lunenburg County - one part-time physiotherapist (two days per week)

Psychiatric Home Visits
- 213 home visits made in 1985

Queens County

Community Health Nursing
- Liverpool (in hospital) - two CHNs, one CNA

VON
- Queens County Branch - one full-time nurse

Hospital Home Care
- Liverpool (Queen's General) - occasional provision of home oxygen equipment

Home Physiotherapy Program
- Queens County - one full-time physiotherapist

Psychiatric Home Visits
- 118 home visits made in 1985

Hants County

Community Health Nursing
- Windsor - one Supervisor, three CHNs, one CNA
- Shubenacadie - two CHNs, one CNA
- Kennetcook - one CHN

VON
- Hants West Branch - one full-time nurse and one part-time nurse

Home Physiotherapy Program
- Hants County - one part-time physiotherapist (two days per week)

Psychiatric Home Visits
- 31 home visits made in 1985

Kings County

Community Health Nursing
- Berwick (in hospital) - two CHNs, one CNA
- Kentville - six CHNs

Hospital Home Care
- Kentville (Valley Health Services Association) - twelve concentrators and two respirators in Home Oxygen Program

VON
- Kings County Branch - two full-time nurses, one part-time nurse

Psychiatric Home Visits
- 53 home visits made in 1985

Annapolis County

Community Health Nursing
- Annapolis Royal (in hospital) - one CHN
- Middleton (in hospital) - two CHNs, one CNA

Hospital Home Care
- Middleton (Soldier's Memorial) - two concentrators in Home Oxygen Program

VON
- Annapolis County Branch - one part-time nurse

Psychiatric Home Visits
- 58 home visits made in 1985

Digby County

Community Health Nursing
- Digby (in hospital) - three CHNs, one CNA
- Freeport - one CHN
- Meteghan - two CHNs, one CNA

Hospital Home Care
- Digby (Digby General) - one respirator in Home Oxygen Program; prepare meals for Meals on Wheels Program for a fee

Psychiatric Home Visits
- 92 home visits made in 1985

Yarmouth County

Community Health Nursing
- Yarmouth (in hospital) - one Supervisor, four CHNs, one CNA
- Pubnico - one CHN, one CNA

Hospital Home Care
- Yarmouth (Yarmouth Regional) - provides meals for Meals on Wheels Program for a fee; provides storage space for loan equipment and materials for the Cancer Society and Red Cross

VON
- Yarmouth Branch - two full-time nurses

Psychiatric Home Visits
- 34 home visits made in 1985

Shelburne County

Community Health Nursing
- Barrington - two CHNs, one CNA
- Shelburne (in hospital) - two CHNs, one CNA

Hospital Home Care
- Shelburne (Roseway) - one concentrator in Home Oxygen Program; provides meals for Meals on Wheels for fee; on occasion provides transportation for patients to and from hospital for physiotherapy

Psychiatric Home Visits
- 47 home visits made in 1985

APPENDIX 2: HOME CARE SERVICES FUNDED BY THE DEPARTMENT OF SOCIAL SERVICES AND OTHER COMMUNITY HOMECARE SERVICES

The following inventory of services was compiled from a questionnaire which was circulated and completed by the rehabilitation counsellors of the Department of Social Services and the Homemakers' agencies throughout the province. Because of differences in interpretation and familiarity with the area in question, it is likely that not all services in each county have been identified. However, the inventory does give an indication of the wide variety of services available in the province.

Cape Breton County

Homemakers Services
- Citizens Service League - Glace Bay - municipal
- Dominion Visiting Homemaker Services - municipal
- New Waterford Service Society - private
- Northside Homemakers Service Agency - private
- Sydney Homemakers Society - private

Meals on Wheels
- Glace Bay, Citizens Service League
- Sydney, St. Rita's Hospital
- New Waterford, Maple Hill Manor

In-Home Supports
- Glace Bay
- North Sydney

Handypersons
- Northside Homemakers Service Agency

Transportation
- Handi Trans (disabled) - Industrial Cape Breton
- Red Cross (Sydney)

Information and Referral
- Citizens Service League

Friendly Visitors
- Glace Bay, Citizens Service League
  Churches and Fraternal Lodges
- Sydney, Care for Families Who Care

Snow Shovelling
- Citizens Service Leaque

Alert
- Glace Bay, Citizens Service League
- Sydney, Police Department
- Sydney area, Red Cross Telephone Check Line

Respite Care
Glace Bay, Citizens Service League
Sydney, C.T.C. (mentally retarded children)

Day Care
Harbourview Hospital

Richmond County

Homemakers Services
Municipality of Richmond County Homemakers Services - municipal

In-Home Supports
Richmond

Friendly Visitors
Petit de Grat Christian Service
St. Ann Centre, L'Ardoise
Richmond Villa Action Group

Alert (blue light)
Service Clubs (admin by homemakers service)

Respite Care
Homemakers Services

Equipment etc.
Red Cross

Inverness County

Homemakers Services
Inverness County Homemakers Services - municipal

Transportation
Evergreen Senior Citizens Club
- Port Hawkesbury

Friendly Visitors/Shopping
Evergreen Senior Citizens Club/Senior Support Service
- Port Hawkesbury

Meals on Wheels
Senior Support Service - Port Hawkesbury

Blue Light
Senior Support Service/Lionesses - Port Hawkesbury

In-Home Supports
Inverness

Victoria County

Guysborough County

Homemakers
Guysborough County Homemakers Services - municipal
Town of Mulgrave Homemakers Services - municipal
St. Mary's Homemakers Services Association - private

Handypersons (includes emergency snow shovelling)
St. Mary's Homemakers Services Association
Guysborough County Homemakers Services

Meals on Wheels
St. Mary's, MacKaracher's Nursing Home

In-Home Supports
Guysborough
St. Mary's

Friendly Visitors
Mulgrave, Homemakers Services
Church groups

Alert
Mulgrave, Royal Canadian Legion

Equipment
Red Cross

Antigonish County

Homemakers
Antigonish and Area Homemakers Services - private
Antigonish County Homemakers - municipal

Handypersons
Antigonish and Area Homemakers Services

Tel-u-care, Friendly Visiting, etc.
Antigonish Town and County Home Care Society

In-Home Supports
Antigonish (town)
Antigonish (county)

Pictou County

Homemakers
Pictou County Visiting Homemakers - private
Children's Aid Society of Pictou County - private

Handypersons
Valley View Villa (Pictou)

Alert
Westville, Blue Light Alert (Town of Westville)

Helpline
Valley View Villa

Respite
Pictou County Homemakers
CTC, Pictou

Snow Shovelling
Senior Citizens Group of Pictou County

Meals on Wheels
Stellarton/New Glasgow, Riverton ARC

Wheels to Meals
Pictou County, Valley View Villa

In-Home Supports
Pictou County
Stellarton
New Glasgow

Transportation
Pictou County Transit Authority operates vans in the Pictou/New Glasgow region
Pictou County, Transit Action for the Disabled
Senior Citizens Help Line
Canadian Cancer Society

Colchester County

Homemakers
Children's Aid and Family
Services of Colchester County - private

Respite
Hillcrest Manor, Truro

Transportation
Willow Lodge, Tatamagouche
Lida (Disabled Org.), Truro area
Able Transit, Disabled Consumer Assn., Truro area
Canadian Cancer Society

Meals on Wheels
Tatamagouche, Willow Lodge
Truro, Hillcrest Manor

In-Home Supports
Colchester

Friendly Visitors
Church groups
Red Cross (Truro)

Alert
Canada Post

Equipment
Lung Association
Red Cross

Cumberland County

Homemakers
Family and Children's Services of Cumberland County - private

Transportation
Amherst, Red Cross

Meals on Wheels
Amherst, Highland View Regional Hospital

In-Home Supports
Parrsboro
Cumberland
Oxford
Springhill
Amherst

Adult Day Care
S. Cumberland Memorial Hospital, Parrsboro

Equipment
Red Cross
Cancer Society

Halifax County

Homemakers

Red Cross Homemakers	- private
Homemakers Bureau	- private
CAS of Halifax	- private
Family Service of Support	- private
Dartmouth Community Homemakers	- private
Dartmouth Senior Citizens Service Centre	- private
City of Halifax Home Care Services	- municipal
Municipality of Halifax County Homemakers Services	- municipal

Handypersons
  Dartmouth Senior Citizens

Respite
  Dartmouth Community Homemakers
  Northwood
  Oakwood Terrace (Dartmouth)
  Red Cross
  CAMR Halifax
  Attendant Care
  HIL Home Supports Association
  CTC, Dartmouth
  Cerebral Palsy Association
  Homemakers Bureau

Transportation
  Dartmouth Social Services
  Dartmouth Senior Citizens
  Red Cross
  Access-a-Bus
  Handi-Bus, Dartmouth (private)
  Callow Veterans and Invalids Welfare League
  Northwood
  CPA (emergency only)

Friendly Visitors
  VON (Halifax)
  Dartmouth Social Services
  Dartmouth Senior Citizens
  Spencer House (Halifax)
  Red Cross
  Church groups
  Leisure Buddy's Program
  Admiral Westphal Sr. Friendship (Dartmouth)
  Basinview Senior Citizen Centre (Halifax)
  Dartmouth Organization of Volunteer Efforts
  Friendship in Action
  Halifax Northend Volunteer for Seniors
  Salvation Army Family Services

Self-help Co-op
  DIAL, Park Victoria, Halifax

Snow Shovelling
  Dartmouth Senior Citizens
  Spencer House
  Coalition of Supportive Services

Day Program
  Northwood
  Dartmouth Senior Citizens
  Spencer House
  Birches, Musquodoboit Harbour

Alert Programs
- Spencer House
- Dartmouth Senior Citizens
- Junior League (Halifax)
- Northwood Telecare
- Chubb Security Safes (private)
- Red Cross Telephone Chain (Halifax)

Equipment
- Canadian Cancer Society
- CNIB
- Red Cross
- Canadian Rehab for Disabled
- Muscular Distrophy Association

Lunch Program
- Spencer House
- Dartmouth Senior Citizens
- St. Mark's (church)

Meals on Wheels
- Dartmouth (private)
- Halifax (City), Veith House
- 3 private agencies

Musquodoboit Valley Memorial Hospital

Wheels to Meals
- Spencer House
- St. John's United Church (Halifax)

In-Home Supports
- Dartmouth

Information and Referral
- Seniors Info-Line
- Spencer House
- Dartmouth Senior Citizens
- Help Line

Hants County

Homemakers
- Homemakers Services of Hants County - municipal

Handypersons
- Homemakers Services of Hants County

Friendly Visitors
- Homemakers Services of Hants County
- War Amps Homemaker Service
- Cancer Society
- Arthritis Society

Snow Shovelling
Homemakers Services (Windsor)

In-Home Supports
East Hants
Hantsport
Windsor

Information Line
Homemakers Services

Meals on Wheels
Slick Meals on Wheels

Transportation
Homemakers Services (limited)
Cancer Society (W. Hants)

Alert
Homemakers Services

Respite
Homemakers Services

Lunenburg County

Homemakers
Family and children's Services of Lunenburg County - private

Meals on Wheels
Chester area, private
Lunenburg area, Harbour View Haven
Mahone Bay, Mahone Nursing Home
Bridgewater, Hillside Pines (pending)

In-Home Supports
Lunenburg District
Mahone Bay
Town of Lunenburg
Bridgewater
Chester

Transportation
Hillside Pines (Home for Special Care)

Alert
RCMP - Lunenburg
Kinsmen - Bridgewater

Respite
Family and Children's Services

Equipment
Red Cross
Lions and Other Service Clubs

Kings County

Homemakers
Family and Children's Services of Kings County - private
Kings County Homemakers Services - municipal

Meals on Wheels
Wolfville area, Flower Cart
Kentville area, Miller Hospital

In-Home Supports
Kings
Wolfville

Queens County

Homemakers
Queens County Homemakers - private (CAS)

Handypersons
Queens County Homemakers

In-Home Supports
Queens
Liverpool

Respite
Queens County Homemakers
Queens Manor

Friendly Visitors
Senior Citizens Club
Church Groups

Helpline
South Shore Help Line

Snow Shovelling
Queen's County Homemakers

Equipment etc.
Red Cross
Cancer Society
Liverpool Lions Club

Wheels to Meals
Family & Children's Services

Annapolis County

Homemakers
Homemakers Services of
Annapolis County - private - (CAS)

Handyperson
Annapolis

Transportation
Valley Drug Mart Ltd. (no cost)

Friendly Visitors
Concerned Seniors, Bridgetown

Information and Referral
Information and Resource Centre

Digby County

Homemakers
Municipality of Clare Homemakers Services - municipal
Municipality of Digby Homemakers Service - municipal
Town of Digby Homemakers Services - municipal

Respite
Villa Acadienne, Meteghan
CTC, Digby

Meals on Wheels
Clare, Villa Acadienne
Town of Digby, Digby General Hospital
Town of Digby, Homemakers Services

Wheels to Meals
Digby County (Villa Acadienne)

Alert
Municipality of Digby, Homemakers Services
Town of Digby, Homemakers Services

Equipment
Digby County, Red Cross
Digby County, Cancer Society

Transportation
Digby County, Cancer Society

Visiting
Digby County, Cancer Society

In-Home Supports
Digby District
Town of Digby
Clare

Yarmouth County

Homemakers
Municipality of Argyle Homemakers Services - Municipal
Municipality of Yarmouth County Homemakers Services - Municipal
Town of Yarmouth Homemakers Services - Municipal

Meals on Wheels
Yarmouth, Yarmouth Regional Hospital

In-Home Supports
Argyle

Transportation
Yarmouth area (subsidized taxi service)
Canadian Cancer Society

Respite
Homemakers Services

Equipment
Red Cross
Cancer Society

Alert
Yarmouth (Town) Fire Department

Lunch Program
Rotary Club, Yarmouth

Friendly Visitors
Church groups

Information
Yarmouth Retired and Senior Citizens Information Centre

Shelburne County

Homemakers
Municipality of Barrington and Town of Clark's Harbour Homemakers Services - municipal
Town of Shelburne Homemakers Services - municipal

Respite
Roseway Manor, Shelburne

Meals on Wheels
  Shelburne area, Roseway Manor

In-Home Supports
  Barrington

Transportation
  Lions Club, Shelburne, Barrington
  Bay Side Home, Barrington
  Canadian Cancer Society, Shelburne County

Alert
  Telephone Help Line
  Blue Light and Alert (pending)

Equipment, Medication
  Canadian Cancer Society
  Red Cross
  Lions Club

APPENDIX 3: GENERAL SYNOPSIS OF HOME CARE PROGRAMS AND DELIVERY MECHANISMS

Northwest Territories

- program coordinates health and home support services
- home care does not differentiate between acute and chronic
- all ages eligible
- hospital-based

British Columbia

A. - Home Nursing and Community Physiotherapy Programs coordinate health and home support services
   - all ages eligible
   - acute care only

B. - Long Term Care coordinates home supports for over 65s and the handicapped over 19
   - chronic care is available for Long Term Care clients; health services are provided by programs in A.

C. - All services delivered through Public Health Units, with separate assessors for the three services.

Alberta

- home care does not differentiate between acute and chronic
- program coordinates health and/or home support services
- all ages eligible if health care required; only seniors are eligible for home support without health services
- through appointed Home Care Boards

Saskatchewan

- program coordinates health and/or home support services
- home care does not differentiate between acute and chronic
- all ages eligible
- through elected Home Care Corporations

Manitoba

- program coordinates health and/or home support services and placement in Personal Care Homes
- home care does not differentiate between acute and chronic
- all ages eligible
- through combined Regional offices of Department of Health and Department of Community Services

Ontario

A. - Home Care program coordinates health and home support services for clients requiring specified health services
   - program distinguishes between acute and chronic care, with different levels of service
   - all ages eligible
   - through local programs (30 Boards of Health, 3 hospitals, 4 VON, 1 corporation)

B. - Home Support Program coordinates home support services for seniors (separate entry point from Home Care)
   - through municipal and reserve Social Services departments
C. - Integrated Homemaker Program coordinates home support for seniors and the disabled over 18 through same entry point as Home Care

Quebec

- program coordinates health and/or home support services
- homecare does not differentiate between acute and chronic
- all ages eligible
- through CLSCs (community boards)

New Brunswick

A. - Extra Mural Hospital coordinates short-term health and home support services in certain areas
   - all ages eligible, provided health service required
   - through units of independent hospital board
B. - Community Based Social Services coordinates home support services for over 65s
   - through regional offices of community Social Services
C. - Public Health Units coordinate health and home support services for acute care (30 days or less) in areas not served by EMH
   - all ages eligible for acute care, provided health service required
   - coordinate health services for Long Term Care patients throughout Province
   - Long Term Care only for over 65s
   - home support portion of Long Term Care coordinated by CBSS

Prince Edward Island

- program coordinates health and/or home support services
- homecare does not differentiate between acute and chronic
- all ages eligible
- through Regional Offices of Home Care and Support Division of Department of Health and Social Services

Newfoundland (St. John's Home Care)

- single entry point for acute and chronic home care and for home support services for seniors
- acute and chronic care coordinate health and home support services
- all ages eligible for acute and chronic care, provided health care required
- home support services coordinated for over 65s
- board with representation from local hospitals and the community.

APPENDIX 4
LIST OF INDIVIDUALS AND ORGANIZATIONS CONSULTED BY DATE AND LOCATION BETWEEN AUGUST 1st AND OCTOBER 31st, 1986.

SEPTEMBER 3rd - SYDNEY

Jean Hull	Citizens Service League
Cecilia LeVatte	Volunteer Resource Centre
Donald Dunbar	C.B. Health Coalition
Evan Scott	C.B. Health Coalition
Ursula DuLow	Victorian Order of Nurses
Mary Fraser	Canadian Pensioners Concerned
Daren Chymal	Canadian Pensioners Concerned
John Clarke	C.B. District Council of Seniors & Pensioners
Dan Yakimchuk	C.B. District Council of Seniors & Pensioners
Sandy Bowes	Social Services
Richard Hines	Department of Housing
Bertha Frisson	Senior Citizens Commission
Janet Wilcox	Homemakers Association
George MacEachern	Steelworker
Chalmers Hamilton	Warden, Victoria County
Elinor McArel	Citizens Service League
Frances Butler	St. Rita's Hospital
Walter MacKinnon	C.B. Health Coalition
Eileen LeBlanc	Breton Business Centre
Dr. L. D. MacCormick	C.B. Health Unit
George Chiasson	C.B. Regional Housing Authority
Ted Kelly	Metro V.O.N.
Andy Boehm	Northside Harbour View
Hugh McDonald	County of Cape Breton Social Services

SEPTEMBER 3rd - BADDECK

Duncan Buchanan	Victoria County Memorial Hospital Board Member (VCMH)
Andrew A. Hanam	Pres. Arm of Gold Senior Citizens
Elizabeth Hanam	Pres. Victoria South - Canadian Pensioners Concerned Inc.
Helen Buchanan	Canadian Pensioners Concerned Inc.
Marian MacDonald	Director Social Services
Chalmers Hamilton	Warden, Victoria County
Mavis Cann	South Victoria County Concerned Citizens
Jessella MacDougall	Commerce Member, Victoria County Memorial Hospital
Marilyn Cameron	Commerce Member Victoria County Memorial Hospital
Marie Macdonald	Victoria County Memorial Hospital Board
Virginia Fownes	Victoria County Memorial Hospital Board
Catherine Ann Fuller	Victoria County Memorial Hospital Board
Jacquelin MacDonald	Interested Citizen
Isabel Carmichael	Senior in Alderwood Apartments
Helen Prentice	Interested Nurse, North Shore & District
Merle MacDonald	Interested Citizen
Debbie MacLeod	Interested Nurse

SEPTEMBER 4th - PORT HAWKESBURY

David MacIvor	Administrator Inverness Consolidated Memorial Hospital
Carolyn Martell	Dr. W.B. Kingston Memorial Clinic - L'Ardoise
Lauchie MacDougall	C.B. District Commander, Royal Canadian Legion
Betty Campbell	Co-ordinator Inverness County Homemaker Services
Audrey Boudreau	Co-ordinator of Homemaker Services, Richmond County
Fred Wildsmith	N.S. Senior Citizens Commission
Lynn Martin	Port Hawkesbury Senior Support Service
Moira Wilneff	Co-ordinator Mulgrave Homemakers
Doreen Jamieson	Mulgrave Homemaker
Kenley MacNeill	St. Mark's United Church
Bruce Milson	Municipal Social Services
Mark Rubenstein	Strait Richmond Hospital
Everett Harris	Strait Richmond Hospital
Mary B. Hureau	Strait Richmond Hospital

SEPTEMBER 9th - ANTIGONISH

Hyland Fraser	Warden, County of Antigonish
Sr. Elizabeth Beaton	St. Andrew's Catholic Women's League
June MacIsaac	St. Andrew's Catholic Women's League
Sy Mills	Social Services
Margaret Briand	Girl Guides Association, Antigonish
Marie Boucher	Home Care (Board of Directors)
Cameron MacDougall	Family Service of Antigonish
Ann Marie Chisholm	St. Martha's Hospital
Mary MacAskill	Guysborough County Homemakers
Alicia MacLean	Town of Mulgrave (Chairperson Community Services)
Pauline MacIsaac	Club 60 Antigonish
Audrey Hardy	Lochaber U.C.W.
Deborah Dort	Guysborough Aux. Fire Department
Fred Wildsmith	Senior Citizens' Commission
David Cleveland	United Church
Ramona MacDonnell	Antigonish Right to Life
Miriam Smith	Antigonish Chamber of Commerce
Joan Moore	St. Mary's Seniors, Sherbrooke Old Timers
Bernadette Landry	Pomquet Seniors - Pomquet
Marion Landry	Pomquet Seniors - Pomquet
Beth MacDonald	Department of Health, Antigonish
F. A. C. Galvon, M.D.	Department of Health, Pictou
Blaise MacNeil	Guysborough Memorial Hospital
Nancy Wright	Guysborough Municipal Council Social Services Committee

Dee Dee MacIntyre	Antigonish & Area Homemakers
Agnes Taylor	Department of Health, Pictou
Pecky Smith	Senior Citizens Club 60
Freda Chisholm	Senior Citizens Task Force
Greg MacKenzie	Club 60 Antigonish - Area Council
Lucy MacDonald	C.W.L. of St. Ninian's, Antigonish
Mabel MacDonald	St. Patrick's Parish, Lochaber
Ethel Gunn	St. Mary's Memorial Hospital
Alice Hewitt	St. Mary's Meals on Wheels
Helen Kaiser	St. Mary's Homemaker Services
Barbara Croft	St. Mary's Homemaker Services
Rev. Brenda Shipton	Anglican Parish of Liscomb - Port Bickerton
Mary Ellen MacDonald	Heatherton C.W.L.
Betty Bennett	Antigonish, N. S.
Edna Cameron	Antigonish, N. S.
Victor Belliveau	Antigonish Lions Club
Bill Wesley	Pastoral Care - St. Paul's Anglican Church
Claire MacDonald, R.N.	Martha Home Health Care
Lucy Falconer	Naomi Society for Battered Women
Har LeVatte-O'Neill	Antigonish Women's Resource Centre
Ruth Henderson	Antigonish Recreation
Eric Mullaley	St. F. X. Extension
Edith Hingley	St. James U.C.W.
Ida Mason	St. James U.C.W. & Club 60
Theresa MacDonald	Antigonish Town & Country Home Care Soc.
Marie MacDonald	Hospice Co-ordinator - St. Martha's Hospital
C. Chisholm	Mayor, Antigonish Town

SEPTEMBER 9th - NEW GLASGOW

Alex J. Barclay	Steeltown Friendly Group
Russel Brownell	Council of Senior Citizens
Eleanor Sutherland	Plymouth Senior Citizens & Senior Help Line
Eleanor Fraser	Councillor & Chairperson Social Services Committee, Town of New Glasgow
Susie Fraser	Treas. Central Highlands Assoc. of the Disabled
Elizabeth Thomas	V.O.N. Board Member - New Glasgow
Sharon Livingston	V.O.N. - New Glasgow
Joan Weber	Extended Care Co-ordinator - Pictou
Dr. Ella W. Sangster	Specialist in Gerontology - University of Michigan
Fran Galvon, M.D.	Department of Health
James W. Reid	Pres, Pictou County Council of Seniors
Margaret MacKinnon	Rep. New Horizons - Westville
Sharon Purvis	Heritage Group - Westville
Hank Dunnewold	Warden, Pictou County
Wilfred Wallis	Pictou, Nova Scotia
Katharine MacKenzie	Pictou County of New Horizons
Barbara Brown	Pictou New Horizons
Elsie MacKay	President, Meals on Wheels, New Glasgow
Murray F. Gardner	Pictou County Visiting Homemakers
Marilyn Hanson	Pictou County Visiting Homemakers
Anne Cullen	Pictou County Visiting Homemakers
Norman Ferguson	Pictou County Visiting Homemakers Sutherland Harris Memorial Hospital

Kate Kennedy	Pictou Town Council
Harold C. Smith	Branch 34, Royal Canadian Legion
Patrick Callaghan	Pictou Family Service of Eastern NS
Margaret Anne Dodson	Pictou V.O.N. Board of Management
Wendy MacDonald	Pictou V.O.N.
Grant Kirkland	Visiting Homemakers
Cyril Reddy	Department of Social Services

SEPTEMBER 10th - DARTMOUTH

Basil Patriquin	Dartmouth Stroke Club
Mae Glenister	Dartmouth, Hard of Hearing
Joe Glenister	Dartmouth, Hard of Hearing
Don Mielke	Metro Transit
Cecile Gorman	V.O.N. Dartmouth
Mary E. Timmins	Retired Public Health Nurse
Milson Dixon	Dartmouth Senior Citizens Advisory Council
Josephine M. Ruth	Dartmouth Community Homemakers Association
Geri Luedey	Dartmouth General Hospital (Social Work Department)
Mary Compton	Eastwood Tenants Association
Adrian Gallant	Dartmouth Senior Citizens Club
Edith Muzzatte	South Woodside Senior Citizens Club
Sandy Jolly	V.O.N. Dartmouth
Martin Patterson	Meals on Wheels, Dartmouth
Tom Cleary	Dartmouth Social Services

SEPTEMBER 15th - BRIDGEWATER

Jennifer Dhalla	Family & Children's Services of Lunenburg County
M. Johnston	Family & Children's Services of Lunenburg County
Bea Larder	Family & Children's Services of Lunenburg County
Pauline Himmelman	Mun. of Lunenburg - Hillside Pines
Kaye Chandler	Family & Children's Services of Queens County
Hugh Walker	Senior Citizens' Commission
Winnie Rockwell	Senior Citizens' Commission
Bob McConnell	Family & Children's Services of Queens County
Pat Gabriel	Instructor - Meals on Wheels
Peggy Davidson	Director, Volunteer Service - SSRH
Jo Eisenhower	Trustee - Meals on Wheels
Fred McCallum	Executive Director, South Shore Regional Hospital
Jill Comolli	Director, Veterans Unit, Fishermen's Memorial Hospital Regional Director, G.A.N.S.
Pat Allen	Director of Nursing
Don Roper	Administrator, Hillside Pines
Ronald A. Mosley	Chaplain, Br. No. 24, R.C.L. Bridgewater
Otto L. Feener	Chairman, Hillside Pines, R.C.L. Bridgewater
Frank A. Hammond	President, Br. 24, R.C.L. B'Water
Fred Turpin	Lunenburg Senior Citizens Council
Rev. Greg Pritchard	Board, Family & Children's Services

Maxine Cochran	M.L.A. Lunenburg Centre Minister of Transportation
Mel Pickings	M.L.A. Lunenburg West Minister of Housing
Jim Barkhouse	M.L.A. Lunenburg East
Bill Curry	Administrator - Mahone Nursing Home
Mary Theresa Comer	Provincial Director, V.O.N. for NS
Robert Smith	Bridgewater Police Department
Susan Ivany	Bridgewater R.C.M.P.
Louise Keeley	Dept. of Health Acting Sup. Community Health Nursing
Barbara Curry	Co-ordinator, Help Line South Shore
Allan MacArthur	Lunenburg Co. Reg. Housing Auth.
Glenn Bright	Bridgewater Lions Club
Marie Barnes	Executive Director, Queens Co. VON
Tom Stephenson	Bd. of Directors, Queens Co. VON
Leslie C. Mason	Administrator, LaHave Manor Corp. & Bd. Mbr. Fishermen's Memorial Hosp. & Mbr. Associated Homes for Special Care
Maria de Vries	Chairman, LaHave Manor Corp & Councillor Lunenburg Municipality
Diane Tanner	Vice-Chairman LaHave Manor Corp. & Bd. Mbr of Harbour View Haven Councillor Lunenburg Municipality
Ann Wynn	Secretary Bd. of Directors - Rosedale Home for Special Care
Dorothy Cahoon	Adminis. Rosedale Home, New Germany
R. L. Powers	Chairman, Harbour View Haven, Lun.
Brian M. Selig	Adminis. Queens Manor & Reg. Dir. South Shore Region, Assoc. Homes for Special Care
Pauline Mattinson	Chester Senior Citizens Club
Marv Mattison	Chester - Meals on Wheels

SEPTEMBER 16th, HALIFAX CITY

Hedley G. Ivany	Senior Citizens Commission
Pippa Ells	Comcare
Patricia Conrad	Social Planning Dept, City of Hfx.
Bob Britton	Social Planning Dept, City of Hfx.
Austin Sewell	The Arthritis Society
Marlene MacLellan	Gerontology Assoc. of N. S.
Carol Fagan	Graduate Student
Jean Maynard	Extendicare
Donna MacDougall	Private Health Care, Halifax
Linda McGuire	Home Care Physiotherapy - The Arthritis Society
Anne Leslie	Home Care Physiotherapy - The Arthritis Society
Janet Menzies	Local Council of Women, Halifax
Emma Dicks	Local Council of Women, Halifax
Sister Margaret Guthrie	Sisters Concerned for Senior Citizens
Sister Mary Hache	Sisters Concerned for Senior Citizens
Jean MacPherson	Hfx. Meals on Wheels - volunteer service
Judith MacKenzie	Hfx. Meals on Wheels - volunteer service
Jean E. MacDonald	Local Council & Provincial Council of Women
Joan Corkum	Canadian Cancer Society
Jan White	Canadian Cancer Society
Joan Pace	V.O.N. - Hfx. Branch
Eileen Irwin	V.O.N. - Hfx. Branch

Donna Merriam	Spencer House Seniors Centre
Lucy Riley	Spencer House Seniors Centre
Jack Glassey	Senior Citizens' Commission
Doug Crossman	Canadian Mental Health Assoc.
Catherine MacPherson	Support of Service
Jane Chambers	Meals on Wheels
Bernadette Paul	UpJohn
Marilyn MacDonald	Pallative Care Service - Infirmary
Marilyn Peers	Children's Aid Society of Hfx.
Pius A. Gardner	Can. National Inst. for the Blind
Robert Swan	Homes for Independent Living
Dr. B. K. Hennan	Family Practice
Marla Gotfried	Support of Service
Valerie Gregg	Can. Paraplegic Association
Shifra Richman	Council for Exceptional Children
Patsy Perkins	Council for Exceptional Children
John M. Gray, M.D.	Camp Hill Hospital
Christine Rodney	Continuing Care, Hfx. Infirmary
Gerald R. Coyle	Arthritis Society N.S. Division

SEPTEMBER 23rd - HALIFAX COUNTY

Sharon Richardson	Ocean View Manor
Irene Rose	New Horizons
John Morrison	Ocean View Manor
Richard Exley	Twin Oaks Memorial Hospital
Evelyn Lutwick	Musquodoboit Valley Mem. Hospital
Shirley Anderson	Musquodoboit Valley Mem. Hospital
Stephen Jenner	Musquodoboit Harbour, Retired
Marion Wilcox	Musquodoboit Valley Mem. Hospital
Sandi MacLachlan	Musquodoboit Valley Mem. Hospital
Judith Ron	Musquodoboit Valley Mem. Hospital
Kathryn Belzer	R.N.A.N.S.
Debbie Harvey	Dept. of Social Services, Hfx. Co.
Jack MacNeil	Dept. of Social Services, Hfx. Co.
Carl Jennex	County Regional Housing Authority
Debby Smith	CAMR, Nova Scotia Division
Doug Delamar	St. Margaret's Bay "White Caps"
Ada Smith	Hfx. County Social Services
Ed Mason	Halifax County Social Services
Laura Khamisa	Cobequid Multi Service Centre
Jessie Miller	E.S. - M.R. Homemakers Inc.
Helen MacDonald	Eastern Passage
Dot Jewers	E.S.M.R. Homemakers Inc.
Heather Robinson	D.M.N.H., Sheet Harbour
W. Grant MacDonald	N.S. Senior Citizens' Commission
Sister Sheila McSweeney	Sisters of Charity Committee "Senior Citizens for Senior Citizen's

SEPTEMBER 24th - YARMOUTH

Gordon Cookley	Interested Citizen
Ruth M. Jogo	Digby County Senior Citizens
Hugh MacKay	Roseway Hospital
Nanette Holden	Roseway Hospital
Richard Levy	Digby Branch Red Cross
Irene Corbett	Arthritis Society
Rev. Bill Van Zoost	N.S. Senior Citizens' Commission
Elmer D. Nickerson	Municipality of Shelburne
Jan Morrow	Municipality of Yarmouth
Bill Scott	Municipality of Yarmouth
Debby Miller	Physiotherapist, Digby Hospital
Daneen Robbins	Social Worker, Digby Hospital
Susanne DeWolfe	Dietitian, Digby Hospital
Frieda Balser	Supervisor, Digby General Hospital
Coleen Lewis	Cler/Tres. Village of Weymouth
Lamont Sweet	N. S. Department of Health
L. M. Husbyhan	Town of Lockeport
R. H. Chymist	Town of Lockeport
Barb Acker	Department of Social Services
Alan Merritt	Clerk/Tres. Munic. of Shelburne
Hobart C. Blades	Warden, Munc. of Shelburne
Ed Byrne	D/Mayor, Digby
Dana Thurlow	Councillor, Town of Digby
Sam Cummings	Dept. of Social Services, Yarmouth
Joan Bradshaw	Business & Prof. Women's Club of Yarmouth

Louise Clarke	Y.M.C.A. Ladies Auxiliary
Deborah Windsor	University Ste. Anne Housing Soc.
Douglas Raymond	Dept. of Social Services, Yarmouth
Greg Wiseman	Dept. of Social Services, Digby
Michael Kendrick	Dept. of Social Services
Rev. Noel Cormier	Clergy of Clare - 7 parishes
Delphis J. Comeau	Clerk/Treasurer Clare
Paul Comeau	Warden Municipality of Clare
Christina J. Pothier	Patient-Services Co-ordinator M.S.S. Yarmouth Chapter
Irene d'Entremont	Councillor Town of Yarmouth
Katheryn J. Moses	Administrator, Town of Yarmouth
Charles Crosby	Councillor, Town of Yarmouth
Marjorie McEachern	Mayor, Town of Yarmouth
Wallace Strickland	Manager, Town of Yarmouth Housing Authority
David King	H.O.P.E. of Yarmouth
Ernie Cottreau	Chairperson, H.O.P.E. of Yarmouth
Odette M. MacGillivray	Vice-Chairperson, HOPE of Yarmouth
Ritchie Nickerson	H.O.P.E. of Yarmouth
Ruth Thibauld	Homemaker
Donna Coggins	Homemaker - Clare
Simone Gaudet	Homemaker - Clare
Anna Deveau	Homemaker - Clare
Rev. Bill Newell	Clergyman - Yarmouth
Joyce Hamilton, R.N.	Discharge Planning Co-ordinator Yarmouth Regional Hospital

Mary LeBlanc	Wedgeport Senior Citizens Club
Charlotte LeBlanc	Wedgeport Senior Citizens Club
Joanna d'Entremont	West Pubnico New Horizons
Mariette d'Eon	West Pubnico New Horizons
Georgette H. Amirault	Pres., West Pubnico New Horizons
Lucille d'Entremont	Vice-Pres., West Pubnico New Horizons
Madeleine Amirault	Middle West Pubnico Senior Citizens Home and New Horizons
Edith Greene	Mid. West Pubnico Argyle Horizons Club & Council of Senior Citizens, Yarmouth County
Clara Atkinson	Mid. West Pubnico, Argyle Horizons Vice-Pres.
Hilda Porter	Mid. West Pubnico Argyle Horizons Club
Marguerite Jenkins	V.O.N.
Suzanne d'Entremont	V.O.N.
Nora Dulong	Home Care Aide - Extended Home Life Support Program, Munc. of Argyle
Yvette d'Eon	Home Care Aide - Extended Home Life Support Program
Joan d'Entremont	Co-ordinator of Homemakers Service Yarmouth County
Linda Campbell	Homemaker - Munc. of Yarmouth
Brian Medel	Halifax Herald Ltd.
Evelyn V. Atkinson	Cape Sable Island, New Horizons Group. Box 235, Clark's Harbour, NS
Edna E. Nickerson	Cape Sable Island New Horizons Group
Nettie Conrad	Loyalist Senior Citizens, Shelburne
Jack Conrad	Shelburne County Council of Seniors
Agnes Bourque	Mavillette Seniors Club

Doris Benoit	President, Ladies Auxiliary Saulnierville
Susan Nash	Homemaker Service, Digby
Bonnie VanTassell	Homemaker Service, Digby

SEPTEMBER 24th - KENTVILLE

Yvonne Nichols	Western Kings Memorial Hospital
W.G. Wilson	Western Kings Memorial Hospital
H. Kirk Widden	Community Living Alternative Soc.
Joanne Porter	Flower Cart Sheltered Workshop
Mary Porter	Co-ord. - Kentville Meals on Wheels
R. Brian Taylor	Annapolis Co. Social Services
Stephen Healy	Town of Kentville
Henry Bourgeois	Kings Co. Social Services
Peggy Jones	Eastern Kings Memorial Hospital
Sadie Barkhouse	Eastern Kings Memorial Hospital
Pauline Thompson	Fundy Health Unit
Merv Ungurain	Fundy Health Unit
Cameron Jess	Kings County Housing Repair
Derek Vernest	Kings C.M.H.A. Outreach Employment
Kristy Herron	Kings C.M.H.A. - President
Dr. Len Denton	Kings Reg. Rehabilitation Centre
J. Gregory MacKin	Kings Reg. Rehabilitation Centre

Harry Currie	Kings County Housing Authority
Blanche Borden	Prof. Home Care Services Ltd.
Bill MacLean	Annapolis Royal General Hospital
Dr. Robert Mullan	N.S.M.S. Home Care Committee
Judith MacLeod	Kings Branch V.O.N.
Don McKay	Councillor, Town of Windsor
Earle F. Hood	Mayor, Town of Windsor & President Union of N. S. Municipalities
Vernon Totten	Dept. of Social Services
Barry Costello	Dept. of Social Services Family & Children's Services of Kings Co.
Howard Taylor	K.R.R.C. and V.H.S. - Kings Co.
Don Burgoyne	N.S. Senior Citizens' Commission
Phyllis Holmes, R.N.	Hants Border, N. S.
Florence Graves	Port Williams Seniors
Mary Gillis	Bd. of Direc., Ann. Co. V.O.N.
Sharon Langley	Bd. of Direc., Ann. Co. V.O.N.
Pauline Gates	Exec. Dir., V.O.N. Ann. County
Holly Bursey	Hants West V.O.N.
Fran Swinamer	Dykeland Lodge Home for the Aged Windsor
Joan Ivey	Hants West V.O.N.
Gail MacLean	Kings Branch V.O.N.
Sharon Marshall	President, Kings Branch V.O.N.
Andrew Gunter	M.S. Society - Annapolis County
Carla Scholten	N.S. Hearing & Speech Clinic c/o BFM Hospital - Kentville
Daphne Bishop, B.S.W.	Social Services (Adult Protection)
Susan Frenette	Homemaker Services of Hants County

P. Ruth Smith	Homemaker Services of Ann. Co.
Reg Walker	50 Plus Club New Minas
Mrs. Reg Walker	50 Plus Club New Minas
Bernice McGee	50 Plus Club New Minas
Daisy Oickle	President-50 Plus Club New Minas
Margaret Tymchuk, R.N./B.N.	V.H.S.A. (Personal Interest)
Pat Fraser, R.N.	V.H.S.A. - Mental Health Division
Laurie Little	V.H.S.A.

SEPTEMBER 29th - AMHERST

Tom McCoag	Halifax Chronicle Herald
Norma Cassidy	South Cumberland Day Care Occupational Therapist (Adult)
Rosemary Currie	Direc. of Social Services Cumb. Co.
Beverly MacLeod	Direc. of Social Services, Springhill
Mary Pat Hawley	Family Services - Cumberland Co.
Meg Finley	Oxford Senior Citizens
Ruth Mitchell	Pres. Senior Citizens & Pensioners Cumberland Co. Council
Evelyn G. Price	Interest Citizen - Meals on Wheels
Beverley MacQuarrie	Dir. of Social Services - Amherst
Margaret Peers	Member Pugwash 50 Plus Club
Arlene Chesnutt	50 Plus Club - Pugwash
Don Chitty	Cumb. Regional Housing Authority
Hazel Olsen	Northport Sunrise Citizens
Edith Tattrie	Northport Sunrise Citizens
Evelyn Ackles	Northport Sunrise Citizens

William McKim	Pres. - 50 Plus Club, Pugwash
Guy Brown	M.L.A.
Frank Allen, R.S.W.	Highland View Reg Hospital, Amherst
Ruth Dunnett	Highland View Reg Hospital
Sharon Fairbanks	Highland View Reg Hospital & Amherst Chapter R.N.A.N.S.
James Morris	River Hebert Village Councillor
Sandra Mackey	Prov. Dept. of Social Services Amherst
Don Russell	Prov. Dept. of Social Services Amherst
Mary Mitchell	Rep. for Collingwood Pioneer Club for Seniors
John Schurman	Rep. for Collingwood Pioneer Club for Seniors
Nellie Veno	Golden Years Society - President
Dorothy Cuvilier	Radio Announcing Activities for the Golden Years
June Jackson	60 Plus, Springhill (member)
Muriel Herrett	60 Plus, Springhill (president)
Flora Little	Red Cross, Wentworth (Creations Chairman)
Stan Booch	Legion
Shaun Murphy	Cumb. Co. Mental Health Clinic Social Worker

SEPTEMBER 29th - TRURO

Thomas Moore	Dept. of Housing
Margareth Colburn	Tatamagouche
Shirley Langille	Colchester Housing Authority
James F. Richards	Treasurer, Rotary Club
Yvonne Freitag	V.O.N.
Catherine Grant	V.O.N.
Ina Mayn	Registered Nurses Assoc. of N.S.
Marie McCully Collier	Department of Health
Janine Campbell	Col. Chapter of Registered Nurses Assoc. of N.S.
Greta Mathewson	Diabetes Education Nurse
Verna Marchbank	Interested Person
Allan Marchbank	Interested Person
Evelyn Negus	Can. Pensioners Concerned Interested Senior (Nurse)
Patricia Irving	Good Neighbour Retired Citizens
Mary Sheppard	Interested Citizen
Ruth Sherman	Rehabilitation
Harvey J. MacArthur	C.A.S. & Family Services of Col. Co., Dept. of Social Services
Betty Gruchy	Pres. of Bd., C.A.S. & Family Services of Col. Co.
Mary Mills	Interested Citizen
Norma Ramsay	Life Improvement for the Disabled Seniors
Mary J. McFadden	Children's Aid Society & Family Services of Col. Co.

Carol Patton	Children's Aid Society & Family Services of Col. Co., Homemaker Service
Robert Nelson	R. C. Legion, Branch 26 - Truro
Marjorie Millett	Good Neighbour Senior Citizens
Kathryn Lei	Seniors' Complex
Garth Bain	Secretary, Branch 106, R.C. Legion Pres. United Church Men's Club Social Director, Friendly Neighbors
Evelyn Kennedy	Stewiacke Housing Authority
Paul Brown	Colchester Hospital
Lewis Forbes	Disabled Consumers Society of Col.
Shirley Watts	Interested Homemaker
Beulah Gratto	Interested Senior Citizen
Julia Gabris	Former V.O.N. Nurse
Gladys M. Virksanovich	Good Neighbors Senior Citizens
Milo Virksanovich	Good Neighbors Senior Citizens
Elsie Dryden	Homemaker Services
Joan Hains	Homemaker Services
Hon. Ron Giffin	M.L.A.

PROVINCIAL ORGANIZATIONS

JULY 17th

Shirley Holtby	Upjohn Health Care Services
Bernadette Paul	Upjohn Health Care Services

August 6th

Al Foley	Federation of Senicr Citizens and Pensioners of N. S.
Bertha Frisson	Federation of Senior Citizens and Pensioners of N.S.
Edith Harvey	Federation of Senior Citizens and Pensioners of N.S.
Ron Mahar	Federation of Senior Citizens and Pensioners of N.S.
Don MacKenzie	Municipal Social Service Workers' Association
Blair Pellerin	Municipal Social Service Workers' Association

AUGUST 7th

Catherine Randall	Certified Nursing Assistants of NS
Jean Hughes	Nova Scotians for Home Care
Anna Taylor	Nova Scotians for Home Care
Myrna Slater	Nova Scotians for Home Care
Tom Cleary	Nova Scotians for Home Care
Brian Hennen, M.D.	Nova Scotians for Home Care

AUGUST 13th

Mayor Earle F. Hood	Union of N. S. Municipalities
Sherman Zwicker	Union of N. S. Municipalities
Myrna Slater	N. S. Pensioners Concerned Inc.
L. Turner	N. S. Pensioners Concerned Inc.

AUGUST 21st

Mary Comer	Registered Nurses Assoc. of N.S.
Anna Taylor	Registered Nurses Assoc. of N.S.
Marlene Grantham	Registered Nurses Assoc. of N.S.
Marie McCully Collier	Registered Nurses Assoc. of N.S.

AUGUST 26th

Ken Brown	The Royal Canadian Legion, N. S. Command
Gordon Armstrong	The Royal Canadian Legion, N. S. Command
Jerry Holland	The Royal Canadian Legion, N. S. Command
Patricia Conrad	Gerontology Assoc. of N. S.
Joan Lay	Gerontology Assoc. of N. S.
Marlene MacLellan	Gerontology Assoc. of N. S.
Fran Sutherland	Gerontology Assoc. of N. S.
Norma Cassidy	Gerontology Assoc. of N. S.

SEPTEMBER 5th

E. Taylor	Seniors Home Care Action Committee
P. Shaw	Seniors Home Care Action Committee
R. W. Clarke	Seniors Home Care Action Committee
M. Parkin	Seniors Home Care Action Committee
E. Logan	Seniors Home Care Action Committee
D. Torrenson	Seniors Home Care Action Committee
J. Miller	Seniors Home Care Action Committee
L. Riley	Seniors Home Care Action Committee
Ian Johnston	Seniors Home Care Action Committee
J. Baxter	Seniors Home Care Action Committee

SEPTEMBER 16th

Alderman Gerald O'Malley	City of Halifax - Task Force on the Aging Population
Edward Roach	City of Halifax - Task Force on the Aging Population
Harold Crowell	City of Halifax - Task Force on the Aging Population
Howard Oehmen	City of Halifax - Task Force on the Aging Population
Patricia Conrad	City of Halifax - Task Force on the Aging Population

SEPTEMBER 18th

Hedley Ivany	St. John Ambulance
Ian Robinson	St. John Ambulance
Malcolm MacAulay	St. John Ambulance

Tony MacAskill	St. John Ambulance
Donna Billard	St. John Ambulance
Peter Holms	St. John Ambulance
John Coddle	St. John Ambulance

SEPTEMBER 19th

Dr. Judy Kazimirski	The Medical Society of N.S.
Dr. Brian Hennan	The Medical Society of N.S.
Dr. Bill Martin	The Medical Society of N.S.

SEPTEMBER 24th

Joan Lay	Assoc. Homes for Special Care NS
Anne Kennedy	Assoc. Homes for Special Care NS
Janet Johnston	Assoc. Homes for Special Care NS
Sheldon Langille	Assoc. Homes for Special Care NS

SEPTEMBER 25th

Winnie Milne	The Canadian Red Cross Society Nova Scotia Division
Laura King	The Canadian Red Cross Society Nova Scotia Division
Ken Bendalier	The Canadian Red Cross Society Nova Scotia Division
Bob Barnes	The Canadian Red Cross Society Nova Scotia Division
Joan Redmond	The Canadian Red Cross Society Nova Scotia Division

SEPTEMBER 26th

Mary Comer	V.O.N. of Canada - N. S. Division
Mary Mosher	V.O.N. of Canada - N. S. Division
Roger Carol	V.O.N. of Canada - N. S. Division
Sharon Marshall	V.O.N. of Canada - N. S. Division

OCTOBER 16th

Edward L. Roach	Northwood Care Inc.
Richard Sevigny	Family Service of Eastern N. S.

OCTOBER 24th

Elaine Churchill	N. S. Society of Occupational Therapists
Liz Townsend	N. S. Society of Occupational Therapists
Stacy Akroyd-Stolarz	N. S. Society of Occupational Therapists

OCTOBER 25th

Helen Sweet	Can. Physiotherapy Association Nova Scotia Branch
Janet Schultze-Jones	Can. Physiotherapy Association Nova Scotia Branch
Ann Lea	Can. Physiotherapy Association Nova Scotia Branch
Janet Leigh Schaffner	Can. Physiotherapy Association Nova Scotia Branch
Ann Leslie	Can. Physiotherapy Association Nova Scotia Branch
Lea Harvey	Can. Physiotherapy Association Nova Scotia Branch
Dr. Arnold Sommerfeld	Pharmacy Association of Nova Scotia